

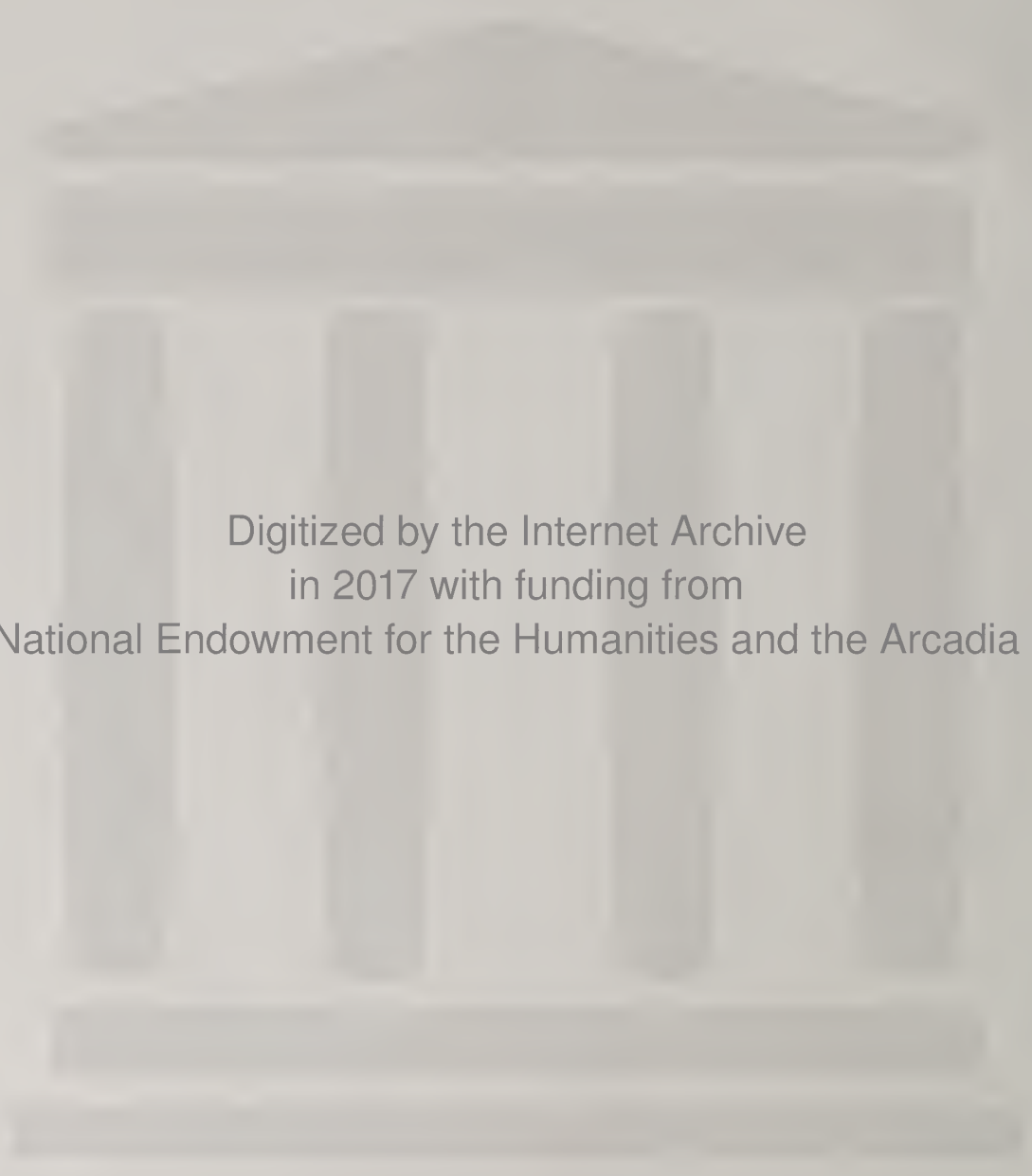
COUNTWAY LIBRARY



HC 3HXK 6

THE FRANCIS A. COUNTWAY LIBRARY OF MEDICINE  
HARVARD MEDICAL LIBRARY-BOSTON MEDICAL LIBRARY





Digitized by the Internet Archive  
in 2017 with funding from  
The National Endowment for the Humanities and the Arcadia Fund



# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

K. Samuel Hippocrates, M.D.

777 Groves Drive

Aesculapius, AL 00000

Patient: Mrs. Nancy Johnson

4/16/65

O. V.

7.50

Lab

3.00

=====

Amount due \$10.50  
 LIBRARY OF MEDICINE  
 BOSTON, MA  
 AUG 21 1991

## THE PAST (Circa 1965)

### HCFA Blinks

by William D. Lazenby, M.D., pg. 12

### The 60s Medicare Debate Revisited

by S. Lon Conner, pg. 4

born in bitter controversy 25 years ago, Medicare is once again a bone of contention because of HCFA's attempt to circumvent the government's own promises to the profession and the law itself in the 16% reduction in the conversion factor.

Resident William D. Lazenby, M.D., looks at the present controversy while Executive Director, Lon Conner reviews the traumatic birth of Medicare.

## THE PRESENT (Circa 1991)

$$\text{Payment} = [(RVU_{w \times GPCI_w}) + (RVU_{pe \times GPCI_{pe}}) +$$

$$(RVU_{m \times GPCI_m})] \times CF$$

$$\text{Work RVU } (RVU_w) = 0.52.$$

$$\text{Practice expense RVU } (RVU_{pe}) = 0.55.$$

$$\text{Malpractice RVU } (RVU_m) = 0.04.$$

Next, locate Birmingham in Addendum C.

Note that the GPCI values for work,

practice expense and malpractice as follows:

$$\text{Work GPCI } (GPCI_w) = 0.981.$$

$$\text{Practice expense GPCI } (GPCI_{pe}) = 0.913.$$

$$\text{Malpractice GPCI } (GPCI_m) = 0.824.$$

Finally, using 26.873 as the uniform national CF,

place the values into the formula provided

**and compute:**

$$\text{Payment} = [(RVU_w \times GPCI_w) + (RVU_{pe} \times GPCI_{pe})$$

$$+ (RVU_m \times GPCI_m)] \times CF$$

$$\text{Payment} = [(0.52 \times 0.981) + (0.55 \times 0.913) +$$

$$(0.04 \times 0.824)] \times 26.873$$

$$\text{Payment} = [(0.51) + (0.50) + (0.03)] \times 26.873$$

$$\text{Payment} = [1.04] \times 26.873$$

$$\text{Payment} = \$27.95$$

(Full Fee Schedule Payment)

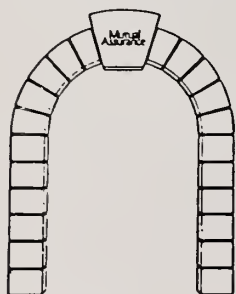
**RARELY ARE THERE EASY  
ANSWERS,**



YAWTKUIC \* 2  
3WKO03 \* 10  
A11, - 2  
1 1 1 1 1

**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 1, JULY 1991

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1991 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Myers, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Joel C. Pittard, M.D. (1992); Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Hartselle. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightsfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

## EXECUTIVE DIRECTOR

S. Lon Conner

Secretary-Treasurer - Emmett Wyatt

## DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

*I.C. System Offers New Collection Programs*.....2  
I.C. Systems, Inc.

Executive Director.....4  
*The 60s Medicare Debate Revisited*

President's Page.....12  
*HCFA Blinks*

*Congestive Heart Failure*.....14  
Michael A. Moore, M.D.\*

*Futures In Your Future*.....18  
George Kleinman

*On Bad Doctors*.....22  
Michael A. LaCombe, M.D.

Classifieds.....25

Auxiliary.....26  
*Guatemala/Medical Auxiliary*

*Retirement Planning Needs*.....29  
AMA Investment Advisers

*A Teenager Looks at Malpractice*.....31  
Brian Caveney

**COVER:** This may be a nostalgia trip for older physicians, those who remember how simple it was in the dear, dead days before the passage of Medicare/Medicaid in the summer of 1965. At top left is a fairly typical doctor bill of the period; on the right is an actual example of Medicare fee computation from HCFA's proposed rule change in the *Federal Register* for June 5. On pg. 12, President William D. Lazenby, M.D., comments on HCFA's infuriating attempt to impose a 16% cut in the Medicare conversion factor for 1992. On pg. 4, Mr. Conner uses the occasion to review the history of Medicare's passage 26 years ago. *Cover by Beth Anne Palmer, Montgomery.*



# I.C. System Offers New Collection Programs

*I.C. System, Inc.*

St. Paul, MN . . . I.C. System, Inc., the collection agency endorsed by MASA, has been providing ethical, effective debt collection service since 1938. Until now, I.C. System has had one basic collection program with optional features. However, as excellent and as flexible as that program is, it does not fit every creditor's needs. Therefore, for the first time in its 53-year history, I.C. System is offering three different collection programs.

I.C. System has just introduced two brand new products, Rapid Recovery' and Recovery Plus' Collection Services. The company is also continuing to offer its familiar and very popular program, now titled Premier Collect' Collection Service. So it is possible for virtually all members of our organization to choose an affordable collection service that meets their specific needs.

If you have only a few accounts that are delinquent, or if your debts are typically under \$100, Rapid Recovery' may be just what you're looking for. It is also an excellent program when you want to prompt debtors to make their payments. I.C. System sends your debtors four collection letters. A collection letter from an independent attorney is also included in the service. Debtors pay you directly, and you don't owe any collection commission. There is a flat fee for the number of accounts you purchase. The larger the package of accounts you choose, the lower the per-account price.

Rapid Recovery' is an easy-to-administer program that lets you focus on your own business priorities while increasing your cash flow. Debts are simple to submit on I.C.'s forms.

If your typical debt is over \$100 and less than six months old, you may want to choose Recovery Plus'. Like Rapid Recovery', you purchase the number of accounts you think you'll need, at a flat per account fee.

Recovery Plus' starts out with a series of four collection letters and a demand letter from an independent attorney. That's the first phase of the collection process. However, if a debt is not collected in Phase 1, it may be transferred automatically to more intensive collections in Phase 2. The debtor pays you

directly in Phase 1, and no commission fees are charged. In Phase 2, the debtor pays I.C. System, and a commission fee is charged.

You may submit Recovery Plus' debts on the submittal forms, computer printouts, tapes, disks or copies of ledger cards.

Premier Collect' is the full service collection program that many of our members are already using successfully. If your debts are typically more than \$100 and sometimes over six months old, you may need this highly effective, comprehensive program. With Premier Collect', you pay an initial enrollment fee plus commissions on the money that I.C. recovers for you.

With Premier Collect', you are guaranteed that I.C. System will collect at least 10 times the amount of the service enrollment fee.

Premier Collect' uses intensive collection efforts that include letters, a demand letter from an independent attorney, telephone calls from professional collectors, listing of debts with the national credit reporting agencies, limited skip-tracing and optional litigation referral service.

You may submit your accounts on easy-to-use forms, computer print-outs, tapes, disks or copies of statement/ledger cards.

With all three programs you can submit both commercial and consumer debts. You also get these features:

- an indemnity agreement that protects you from legal consequences that might occur as the result of I.C. System's collection efforts
- the options of using TRACKDOWN® Debtor Locator Service and InstiCredit® Credit Reports
- the services of I.C.'s Client Services Department, which can be contacted on a toll-free 800 telephone number.

I.C. System has collected over \$1 billion for its clients. Its collection services are endorsed by over 1,100 trade and professional organizations, and it serves clients in all 50 states. If you would like more information on how this national collection agency can benefit you, contact the MASA office or call 1-800-325-6884.

# AIM HIGH



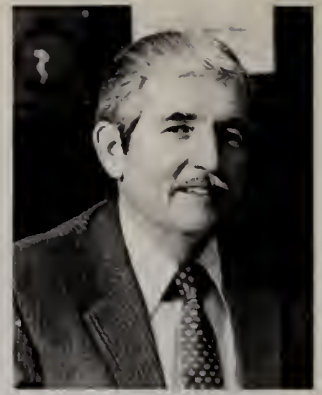
## BE AN AIR FORCE PHYSICIAN.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. And enjoy the satisfaction of a general practice without the financial and management burden. Today's Air Force offers an exciting medical environment and a non-contributing retirement plan for physicians who qualify. Learn more about becoming an Air Force physician. Call

**USAF  
HEALTH PROFESSIONS  
1-800-423-USAF  
TOLL FREE**







S. Lon Conner  
Executive Director, MASA

## The 60s Medicare Debate Revisited

In the current rancor over HCFA's crude arrogation of legislative power in the conversion factor imbroglio, there are distinct echoes of the 1960s debate leading up to the enactment of Medicare/Medicaid.

In fact, re-reading the official history of the AMA on the subject, (in Frank D. Campion's *The AMA and U.S. Health Policy Since 1940* ©1984, AMA, Chicago) would, I am sure give, give some senior Delegates to AMA frequent attacks of *deja vu*. Then, as now, the central issue to physicians was a perceived oxymoron, federal health care.

The rhetoric was similar in many ways, and different in many other ways. The first president to propose national health insurance, Harry S Truman, got nowhere. The idealistic President John Kennedy, although he embraced the concept of Medicare and stumped for it, never really had his heart in it. All these efforts were beaten back by massive AMA resistance, by instilling public doubt and by effective lobbying in Washington.

But the early battles, in which AMA found itself slugging it out with organized labor for the hearts and minds of the people, had taken a heavy toll. One could even characterize those early successes as Pyrrhic victories. That was, in fact, the way they were labeled by a small number of sincere, eloquent and concerned physicians. Led by Russell B. Roth, M.D., this embattled minority persisted in the advocacy of medicine's making an accommodation with the feds and with the Medicare movement. In the environment of AMA majority sentiment of that period, their position was nothing if not courageous. It could have

even been called foolhardy; and it was even called treason to the cause of medicine.

But the dissenters' position was also prophetic. So, perhaps, was the overwhelming majority view that government and medicine are as immiscible as oil and water.

Although the antecedents to the fight go far back, the battle was really joined under President Kennedy. In November 1961, the White House staged 12 regional conferences on the health problems of the aged, featuring speeches by cabinet members and other high administration officials in support of the framework that was to become the King-Anderson bill.

Earlier, Senator Pat McNamara of Michigan had taken a Senate Subcommittee on the Problems of the Aging around the country to stage medical horror stories from people supplied by local labor organizations. AFL-CIO and its affiliates were by this time in full mobilization behind the prototype of King-Anderson.

All the while, Health, Education & Welfare Secretary Abraham Ribicoff was using his office to broadside AMA as obstructionist and coercive, a medical tyranny that routinely whipped its members into line behind antediluvian policies. He called the AMA President a "reluctant dragon." and in general badmouthed doctors in much the same language as we hear today from the likes of Pete Stark.

AMA very properly complained that federal money and personnel were being wrongly employed in a partisan political cause. But the attorney general was Bobby Kennedy and the AMA complaint was



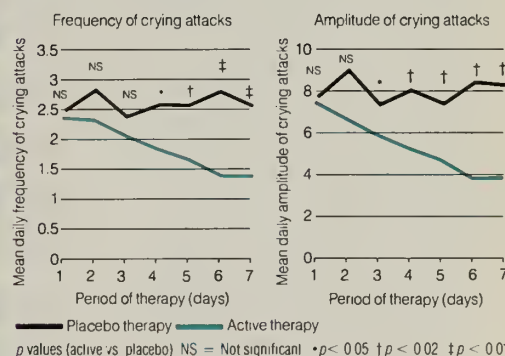
# Family therapy for colic.

The excessive crying of colic puts a strain on the most loving family—and often on their physician as well. And whatever the cause of colic, one fact is clear:

## Gas is often part of the colic problem.

New Phazyme Drops contains simethicone, which can safely break up gas and bring baby relief. That's why it can help whenever colic is a problem.

## Significantly reduces crying of colicky infants.<sup>1</sup>



Double-blind, randomized, placebo-controlled study

## Priced 25% below the leading brand.

This significant price advantage will be particularly important to parents, since they may be relying on Phazyme Drops for up to three months. And it's naturally flavored—something else they'll appreciate.

NEW   
**Phazyme Drops** (simethicone/antigas)  
**Helps you through the colic phase.**

1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508



never heard from again. As the rhetoric escalated, more than a few physicians began to worry about the unseemliness of their profession locked in an apparent death struggle with working people and the elderly. What made it marginally acceptable was the fact that AFL-CIO and the ad hoc National Council of Senior Citizens were being funded by the U.S. Labor Department.

That outrage, along with the drumbeat of defamatory language in labor's hate campaigns, at least eased the distaste of those physicians who thought the profession had no business embroiled in an unsavory contest, even if labor propaganda identified them as "witch doctors." The American physician, this concerned group believed, should never stoop to conquer.

As 1961 came to a close, it was pretty much a dogfall between medicine and the labor-government-elderly coalition. In fact, President Kennedy's campaign pledge to "get the country moving again" was so deeply mired in Congress that the election year ahead, 1962, loomed as a dangerous political quagmire.

Early that year, with an eye on the fall elections, a massive propaganda campaign was launched with a planning session in Boston chaired by James C. O'Brien, a union representative assigned to the White House staff.

The blitz would be gargantuan: over a seven-week period there would be 5,000 speeches given by 250 speakers nationwide, climaxing May 20 with mass rallies in at least 20 key areas. The showcase would be in Madison Square Garden and addressed by President Kennedy himself. Only rarely in history had a President committed himself and his resources to such an orchestrated campaign in support of a piece of legislation.

Kennedy's speech was, by even the most sympathetic appraisal, a real turkey. In the same empty hall, the next night, an empty hall still littered with the bal-

loons, leaflets, coffee cups and other debris of the Kennedy rally, Ed. Annis, M.D. presented the AMA case in a magnificent tour de force that has become the stuff of legend. The setting was perfect, making the point that the "old folks" rally had been rigged, funded and orchestrated by Washington. Dr. Annis thus skillfully depicted the AMA as the underdog in taking on a popular young president who had committed himself to the old folks.

Dr. Annis stole the show, winning heavily on points if not by a knockout. AMA was jubilant. And Kennedy was to go to his death with no medical statute for the aged. By December 1963, Dr. Annis, now President of AMA, could proclaim that the tide had turned toward medicine.

But AMA also knew that it was principally the intransigence of Wilbur Mills, Chairman of House Ways & Means, that had really been the bone in Kennedy's throat. Mills feared anything that might hurt Social Security, and he feared a medical care rider would quickly bankrupt the system. Also, he didn't think the President had the votes he needed; Chairman Mills liked to win. Essentially, it was Mills who blocked King-Anderson from the time of its introduction in 1961 until early 1965.

But AMA was far from unanimous in its support of the vigorous and, at times, downright mean campaign.

The official history cited above notes:

"To the public at this time, the AMA presented a picture of strength, unity and intransigence. Congressmen, HEW officials, the press and others who saw the AMA at closer range noted the same qualities. But they were also struck by the vehemence with which the AMA advanced its views."

Wilbur J. Cohen had been the real architect of health care for the aged within the government. The man who had quietly campaigned for his dream during the 1940s, 1950s, and 1960s, was later asked to

*Kennedy's speech was, by even the most sympathetic appraisal, a real turkey. In the same empty hall, the next night, an empty hall still littered with the balloons, leaflets, coffee cups and other debris of the Kennedy rally, Ed. Annis, M.D., presented the AMA case in a magnificent tour de force that has become the stuff of legend.*

explain the depth of physician animosity to his ideas. He allowed that he didn't fully understand it, but believed its inception was the famous 1932 editorial by Morris Fishbein, M.D., in which the *JAMA* editor said that the Committee on the Costs of Medical Care had issued a report that was an incitement to revolution and appealing to socialism and communism.

Dr. Fishbein's screed was often cited during the 60s as proof of AMA's troglodyte position. Mr. Cohen remained baffled, long after the AMA had been defeated, by the inability, as he saw it, of physicians to understand during this period that their opponents might be as sincere in their beliefs as doctors were in theirs:

"They really couldn't understand why other people wanted national health insurance, and they preferred to believe in the conspiratorial and devil theory: that somebody was trying to do something to them that was unjustified... They simply couldn't imagine anyone being for national health insurance the way I was, simply because I thought it was the right thing to do."

At the end of 1962, Russell B. Roth, M.D., vice chairman of the Council on Medical Service, was growing sharper in his criticism of AMA's negative position, saying the Association was in "a profound state of auto-hypnosis."

In a letter to the Council on Legislative Activities, he wrote:

"By virtue of the togetherness that develops at AMA official sessions, wherein we hear our own lobbyists reporting on their work, listen to the Senators and Representatives we want to hear, and engender in ourselves a collective sense of self-satisfaction and boldness, our top leadership has somehow convinced itself that AMA is doing just fine. My view is that it is lamentably not doing very well at all."

AMA's support of the Kerr-Mills alternative to King-Anderson was unwise, he said, calling Kerr-Mills a poor vehicle of deliverance, "a woefully creaky, sputtery and undependable glory-wagon."

One of Dr. Roth's targets was Max H. Parrott, M.D., a delegate at the time and a member of the Council on Legislative Activities. He later described the mood of the Delegates in 1963-64:

"There were two schools of thought on the matter of whether the AMA ought to have its own bill or not. No, let me amend that. There were three schools of thought: there was the left-wing element that thought we ought to go along with the Administration; we had conservatives who didn't think we should have any bill; and there were liberals who thought we should

have a bill to offset what was being considered in Congress. ... The Board of Trustees, the establishment at that time, [was] in the conservative camp."

Until 1963, the AMA official history says, "the conservatives held the edge over the more liberal-minded physicians in the house."

The secretary to the Council on Legislative Activities recalled that "the only movement toward a positive approach then was coming from the Council on Medical Service and a small group in the House. They were pretty lonesome voices."

When President Kennedy was killed on

Nov. 22, 1963, the mood of the country turned to gloom, overlaid with a vague sense of guilt that the slain President's eloquently articulated social visions had come to naught. Enter Lyndon Johnson, whose political training had begun in the New Deal. Johnson really believed in Medicare, far more passionately than had his predecessor. Additionally, he had been majority leader of the Senate in the 1950s, a master at working the levers of power. He knew how to get what he wanted and, in Medicare, he saw the crown jewel of his Great Society dream. And he knew how to handle Wilbur Mills, who in no time at all was to change his spots to a Medicare advocate.

The AMA's official position was the King-Anderson was a cruel hoax convincing many people that it would cover all or virtually all of their medical expenses when it would not. But by the time of the

*Johnson really believed in Medicare, far more passionately than had his predecessor. Additionally, he had been majority leader of the Senate in the 1950s, a master at working the levers of power. He knew how to get what he wanted and, in Medicare, he saw the crown jewel of his Great Society dream.*



Association's 1964 interim meeting in Miami, it was obvious that Wilbur Mills was collapsing and President Johnson was gaining ground.

It now became clear that the Association's stonewalling would no longer serve, that compromise and barter would be the new game. The minority represented by Dr. Roth began to gain ascendancy. Although two resolutions calling for support of federal programs to assist the elderly were voted down in Miami, a California resolution reaffirmed what had been AMA's position all along — that no person needing care should be denied it because of inability to pay.

While the resolution went on to favor using "existing mechanisms" for this purpose (referring to the already enacted Kerr-Mills, which depended on state action that had not been forthcoming in any great volume), it went on to say that "everyone in need, regardless of age, is assured that necessary health care will be available."

All but lost sight of in the debate over the wording was the key phrase "regardless of age," which had the effect of putting the Association firmly behind Medicaid, based on need, but not Medicare, based on Social Security entitlement.

A few weeks later, the concept of Eldercare was offered by AMA, differing from Medicare in that it would be based on need, or means testing. AMA backed Eldercare with an extensive advertising campaign, advancing such arguments as its relatively lower cost to taxpayers because those who could pay would continue to pay. Eldercare would provide more generous benefits to those genuinely in need of financial assistance, AMA argued.

That campaign cost AMA \$1.7 million in 1965. Medicaid actually grew out of Eldercare, because Mills, by now a convert, insisted on a "three-layer cake," as he called it, a bill incorporating features of all three of the major proposals — King-Anderson, the so-called Byrnes bill, and Eldercare.

Layer one, Medicare part A, was very close to King-Anderson; layer two, Medicare Part B, came out

of the Byrnes bill, a supplemental, voluntary insurance plan covering physicians services; layer three, Medicaid, grew out of the Eldercare bill, Kerr-Mills and the AMA's concern for the non-elderly needy as expressed at the 1964 Miami meeting. At committee hearings in Washington, AMA conceded that the three layer cake had merit here and there, but the Association continued to oppose the total package. For the record, AMA supported only Medicaid and Eldercare.

In expressing its overall opposition, AMA said, "There is no totally effective method or methods which will keep the costs of the program under control."

Note well, for these words have echoed down the years.

Originally estimated at \$6.8 billion a year, Medicare was costing more than double that by 1970, quadruple that by 1975, and ten times the estimate by 1980.

When an AMA-supported motion to recommit failed in the House on April 8, 1965, it was all over but the final vote for passage, 313-115. After Senate affirmation in late July, President Johnson flew to Independence, Missouri, to sign Medicare-Medicaid in the presence of Harry S

Truman, the first president to commit himself to national health insurance.

Medicare was law but the all-important regs had not been written. If the revolutionary new program was to work at all, its survival would depend on the regulatory implementation.

The month before final passage, at the June meeting of the House of Delegates, the mood was still predominantly defiant when Dr. Roth suggested from the floor that if the Medicare bill passed, as then seemed likely, the Board of Trustees or the Council on Medical Service should be deputized to work out the regs with HEW.

A cautious resolution was finally passed restating the House of Delegates' offer to meet with the President through the Legislative Task Force to "discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest

*All but lost sight of in the debate over the wording was the key phrase "regardless of age," which had the effect of putting the Association firmly behind Medicaid, based on need, but not Medicare, based on Social Security entitlement.*

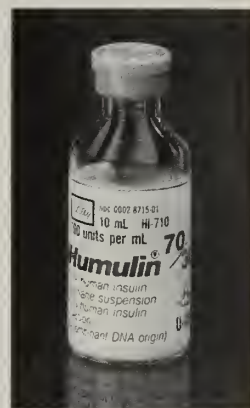


For your insulin-mixing  
or NPH-using patients

## Humulin<sup>®</sup> 70/30 makes life easier

**Rapid onset and sustained  
duration insulin activity  
in a single vial**

- May offer enhanced control through a more physiologic activity profile
- Accurate dosing—eliminates mixing errors
- Convenient premixed dose for better compliance
- Easy to use—for patients who find mixing difficult



**Specify**  
**Humulin<sup>®</sup> 70/30**  
70% human insulin  
isophane suspension  
30% human insulin injection  
(recombinant DNA origin)

**Humulin has  
just the right mix**

Any change of insulin should be made cautiously and only under medical supervision.

Changes in refinement, purity, strength, brand (manufacturer), type (regular, NPH, Lente<sup>®</sup>, etc), species (beef, pork, beef-pork, human), and/or method of manufacture (recombinant DNA versus animal-source insulin) may result in the need for a change in dosage

*Leadership In Diabetes Care*



**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

quality and availability of medical care to the People of the United States.” In late June, one month before final passage, a letter from AMA to the President was sent to the White House, where it was caromed off to Wilbur Cohen for comment and advice.

Cohen advised the President by memo that “the full cooperation of the physicians of this country [is necessary] to make the program work successfully.”

Cohen proposed that the President meet with the AMA task force on the day following final passage, then about two weeks away. The suggestion was accepted at the White House; Cohen drew up a ten-point briefing memo outlining the tack he thought President Johnson should take. He stressed again and again the need to make peace between the previously warring factions — peace and cooperation.

At the meeting, Johnson made the doctor delegation feel at home by first telling them stories and then asking their advice on what to put in the regulations. Then he turned to Cohen and sternly ordered him to listen closely to the recommendations the doctors had to offer. Cohen recalled with a chuckle many years later:

“The doctors got a big kick out of the President telling me what to do. But I was really only telling myself.” By that he meant that Johnson’s order to him, while intended to convey the idea of Cohen’s being taken to the woodshed, was precisely drawn from Cohen’s own memo. Lyndon Johnson was a good ham actor.

To carry on further discussions, the Board of Trustees appointed a seven-man advisory committee. Other meetings followed. AMA history:

“The two presidential meetings and the events of the following months established a new relationship between organized medicine and the federal government. Instead of glowering at each other across a political battlefield, hurling slogans and accusa-

tions, the two sides now addressed each other in civilized tones around a conference table.... Unless the AMA wished to repudiate all its statements about working for the best possible care of the people, it had little choice but to work with government and make the programs as productive of quality care as possible.”

Wilbur Cohen:

*“Enactment of Medicare and Medicaid was a watershed decision, for after 1965 the politics of medicine began to shift, focusing less on the accessibility of care and more on its cost.”*

“It didn’t mean the AMA had to agree with the government. But it did mean that it was desirable to have discussions and constructive suggestions for change growing out of that kind of dialogue. The meetings with the President helped to break the strong feeling against governmental action. Now it was possible for the medical profession to feel that at least it could discuss its views and attitudes and its opposition and its constructive suggestions with government.”

AMA history:

“It was not what the delegates, conditioned by the fighting rhetoric of Ed Annis, wanted to hear right then. The immediate reception of the President’s speech was as quiet and as chilling as anyone could remember. But the following day, when it came time to settle the issue by vote, the delegates accepted Dr. Appel’s leadership. Nothing more was said about the boycott, and they endorsed a policy of working with HEW to translated the Medicare law in a beneficial program.”

The history concludes the chapter on the great battles of the 1960s:

“Enactment of Medicare and Medicaid was a watershed decision, for after 1965 the politics of medicine began to shift, focusing less on the accessibility of care and more on its cost.”

To me this is fascinating history. I have summarized it here at some length, because it is often essential to know where you have been before you can fix a true compass heading on where you want to go.



# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM**

## **\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**



William D. Lazenby, M.D.  
President, MASA

## HCFA Blinks

As this is written, the most compelling news affecting medicine is the bitter flap over the Bush Administration's horrendous proposal to cut the Medicare conversion factor by 16% in the initial year of the Physician Payment Reform legislation.

That legislation came about only after many years of agonizing appraisals and reappraisals of the elements of the Resource Based Relative Value System. The first commandment, agreed upon all around the table, was that whatever emerged would not be used simply as a budget-cutting device.

Obviously, everyone agreed, the pie was to be redivided in a budget neutral fashion. That, after all, was the whole point of the exercise.

In the smoke & mirrors of what Washington budget-balancing has become, however, few things are ever honestly entered on the books. To spare taxpayers the pain of new revenues, Congress and the Presidency cook and re-cook the numbers, shuffle and shift, adding something here and taking it away somewhere else. The budget process, in point of fact, has become the biggest free-floating fraud in American life.

Given this environment of shameless chicanery, it should hardly be surprising that HCFA contributed its bit to the ongoing illusion by its transparent cooking of the numbers in the argument supporting the 16% cut. I will not go into that in detail here for space reasons, but suffice it to say that the manipulation is nowhere more evident than in the specious argument supporting the "behavioral offset" — that curious phrase for the galling assumption that doctors will

greet any reduction in fees by trying to rip off the system via various acts of larcenous intent.

This is insulting to physicians, and reminds me of the famous quip by Cordell Hull, Secretary of State under Franklin Roosevelt: "Never insult an alligator until you have crossed the river."

It was in fact the behavioral offset and further manipulations to it that insulted the alligator called AMA, which responded with the most outraged counterattack that I have witnessed. (We included much of that response in a special supplement mailed with your copy of *Alabama Medicine* in July.)

To HCFA, the American physician is a latterday Willie Sutton. Doctors would, the government agency assumes, connive to increase the units of service if the unit price goes down. I have often thought that this slander is really a calculated attempt at a self-fulfilling prophecy in the context of "game theory" — so infuriate your adversary that he will, out of blind rage, walk right into the trap you have set. (As the AMA's perspicacious Dr. Todd has commented, if physicians do in fact react in such crude fashion to the new fee schedules, they will have only themselves to blame later, having foolishly swallowed HCFA's bait.)

If should be obvious to even the casual observer that in preparing its conversion factor cut, HCFA used a bureaucratic form of reverse engineering: start with the result you want, then work backward to fabricate the tenuous rationale.

Following HCFA's deliberately obfuscated reasoning process and its offered data recalls the justly

famous quote from the late Sir Josiah Stamp, Her Majesty's crusty old (he died at 101) Collector of Internal Revenue. Infuriated once too often by the mass of computer print-outs served up by owl-eyed young functionaries in Her Majesty's government service, Sir Josiah said:

"The government is extremely fond of amassing great quantities of statistics. These are raised to the nth degree, the cube roots are extracted, and the results are arranged into elaborate and impressive displays. What must be kept in mind, however, is that in every case, the figures are first put down by the village watchman, and he puts down anything he damn well pleases."

In HCFA's case, the village watchman is represented by vast armies of drones sitting before CRTs, following orders to prove whatever it is their leaders want to prove. And the size of the HHS bureaucracy, larger by far than that of many whole countries, calls to mind another appropriate observation, attributed to Prof. C. Northcote Parkinson, he of Parkinson's Law:

"An enterprise employing more than 1,000 people becomes a self-perpetuating empire, creating so much internal work that it no longer needs any contact with the outside world."

It may well be that it was this very isolation from the real world that emboldened HCFA to propose so scandalous a betrayal of the good-faith negotiations of medicine. At this writing, even such Senatorial big guns as Lloyd Bentsen, George Mitchell, and Robert Dole had fired off an angry letter curtly informing HCFA Administrator Wilensky that the law reforming Medicare physician fees wasn't crafted to shave billions of dollars from the program.

Eleven other senators of both parties signed that letter to express their outrage over a dishonorable perversion of congressional intent.

Even earlier, the redoubtable Pete Stark, chairman of the House Ways & Means Subcommittee, had

threatened that if HCFA didn't undo the mess it had made, he would. It isn't often that Congressman Stark, who yields to none in his tireless baiting of the American physician, is on the side of organized medicine.

So HCFA must have received a strong message of utter dismay from Congress. Ms. Wilensky could only reply, lamely, that perhaps her folks had misconstrued the meaning of budget neutrality.

Perhaps. But anybody who believes that, anyone who figures it was all an honest lapse, is too innocent of Potomac ways to follow this business anyway.

I seem to be quoting too many authors on bureaucracy, but one more seems inescapable. In its grotesque over-reaching, HCFA appears to have forgotten Truman's Law: "If you can't convince them, confuse them." Thanks to the quick, incisive and virtually unanswerable response of the AMA to the 16% meat-axe, HCFA neither convinced nor confused — anybody.

What we have here is a classic study of a huge and powerful bureaucracy running amok and flagrantly usurping the legislative function. It was that act of brazen arrogance, more than anything else, that raised the hackles of Congress, jealous of its prerogatives even when it does not use them.

At this writing, I don't know how this will play out. But it does appear that HCFA's sails have been trimmed for the time being. Still, I have a lingering suspicion that Congress is not all that clean in the whole fiasco.

Too often in the past Congress has granted HCFA vague statutory authority with whispered instructions in the corridors to propose rule changes to accomplish an objective nowhere spelled out in the legislation itself. If that happened in this case, shame, but perhaps the devious practice will have been ended by exposure.



# Congestive Heart Failure

*Michael A. Moore, M.D.\**

Congestive heart failure is a common clinical entity. The symptoms of paroxysmal nocturnal dyspnea and exertional dyspnea, orthopnea and fatigue, along with physical findings of a third heart sound (S<sub>3</sub>), jugular venous pressure elevation, and crackles or rales on examination of the lungs, and chest radiograph showing cardiomegaly, pulmonary venous hypertension and a pulmonary edema make this entity easy to recognize in most cases. The classical pathophysiologic understanding of congestive heart failure has been of impaired systolic function of the left ventricle, characterized by a falling ejection fraction, compensated for by progressive dilation of the left ventricle, using the Starling mechanism of increasing preload to augment contractility until higher filling pressures eventually lead to pulmonary congestion and associated symptoms of dyspnea. Such an understanding of the physiology of congestive heart failure provided a rationale for the use of digoxin to enhance ventricular contractility, diuretics to lower excessive ventricular preload, and vasodilators to decrease both left ventricular preload and afterload. However, the availability of techniques to assess left ventricular function by measuring left ventricle ejection fraction noninvasively, using echocardiography and nuclear angiography (MUGA scan), has made the identification of a significant subset of patients with congestive heart failure on clinical grounds, who had normal left ventricular ejection fraction possible. Concepts regarding the pathophysiology of congestive heart failure have recently undergone substantial modification, requiring a broader view of this clinical syndrome, and altering our therapeutic approaches to patient treatment as well. The following case provides an illustration of the emerging concept of diastolic dysfunction of the left ventricle.

## CASE REPORT

A 74-year-old black female presented to the emergency room with complaints of shortness of breath. She had a prior history of hypertension and Type II

diabetes mellitus, and had been treated with furosemide and clonidine by her previous physician. She reported progressive exertional dyspnea and concomitant lower extremity edema for several weeks before coming to the emergency room, and furosemide had been only partially effective in relieving these symptoms. There was no history of angina or previous myocardial infarction. On the evening of admission, she had become acutely short of breath without associated chest pain. There was no history of dietary salt indiscretion, medication noncompliance or other concurrent medical illnesses.

Physical examination revealed a blood pressure of 160/92, heart rate 88, respirations 26. She was in moderate respiratory distress. Jugular venous pressures was estimated at 12 cm. of water; lung exam revealed bilateral basilar rales but no wheezing. Cardiac exam was notable for the presence of an S<sub>4</sub> gallop, but no S<sub>3</sub> was appreciated. There was no evidence of organomegaly on abdominal exam, and only 1+ pretibial edema was noted.

Admission chest x-ray showed mild cardiomegaly with pulmonary venous hypertension and interstitial edema. An EKG was compatible with left ventricular hypertension and associated strain pattern. Laboratory studies included a creatinine of 2.4 mg/dl and a BUN of 42.

The patient was treated with IV furosemide with prompt diuresis, resolution of her symptoms of dyspnea and clearing of interstitial edema on chest x-ray. Evaluation included serial cardiac isoenzymes and EKGs, which showed no evidence of acute myocardial infarction. An echocardiogram was performed and revealed concentric hypertrophy of the left ventricular wall but no chamber enlargement; the ejection fraction was normal at 70%. The patient was felt to have congestive heart failure secondary to hypertensive cardiovascular disease. There was concern that transient myocardial ischemia might have precipitated the acute pulmonary edema, but because of her osteoarthritis and limited ability to ambulate, a GXT could not be performed. She was discharged on metoprolol 50 mg. bid, furosemide 80 mg. bid, diltiazem 60 mg. tid and clonidine 0.2 mg. bid.

---

\*The Bessemer Clinic, P.C., Bessemer, Alabama.

Over the next 2 1/2 years, the patient was readmitted on numerous occasions for acute pulmonary edema. Each episode was clinically similar to her initial presentation; acute and severe dyspnea superimposed as a baseline of mild to moderate exertional dyspnea. These episodes occurred despite apparently good compliance with prescribed medications and in the absence of chest pain. There was never any evidence of myocardial infarction, and she was seen on several admissions by cardiology consultants, who felt that this patient was not a good candidate for cardiac catheterization. Each hospitalization was characterized by fairly prompt improvement following administration of diuretic therapy, though she required intubation and temporary ventilatory support several times. A MUGA scan confirmed a normal ejection fraction of 70%, and revealed no evidence of left ventricular wall motion abnormalities. After six hospitalizations for acute pulmonary edema within a span of 18 months, the patient underwent cardiac catheterization in hopes of finding a reversible cause of her repeated symptomatic exacerbations of congestive heart failure. Coronary arteriograms showed only minor coronary artery obstruction, normal left ventricular end-diastolic pressure at rest, and a cardiac index of 2.2 liters/min/m<sup>2</sup>. It was concluded that the patient was suffering from congestive heart failure caused by left ventricular diastolic dysfunction. Efforts to improve the diastolic filling properties of the left ventricle by using a combination of beta blockers and calcium channel blockers were not successful in preventing recurrences of pulmonary edema and repeated hospitalizations in this patient. Four months (and 3 hospitalizations) after her cardiac catheterization, and 2 1/2 years after the initial hospitalization for congestive heart failure, our patient expired from complications of a cerebral infarction suffered during yet another episode of pulmonary edema.

## DISCUSSION

This patient demonstrated classical clinical findings of congestive heart failure; exertional dyspnea and paroxysmal nocturnal dyspnea, rales, jugular venous distention and an S<sub>3</sub> gallop, along with cardiomegaly and pulmonary venous hypertension by chest x-ray. These characteristics are typical of congestive heart failure and compatible with the traditional understanding (and teaching) of impaired systolic function as the cause of this clinical syndrome. However, the finding of a normal ejection fraction, as determined by both echocardiography and by nuclear

angiography, suggested a different pathophysiologic process at work in this patient. Plehn, et al<sup>1</sup> report a group of patients with similar life-threatening episodes of congestive heart failure, yet with normal systolic function. Dougherty, et al<sup>2</sup> describe similar findings in an analysis of a group of 188 patients presenting with a clinical diagnosis of congestive heart failure. Criteria used for establishing the diagnosis on congestive heart failure were derived from the Framingham study<sup>3</sup> and included paroxysmal nocturnal dyspnea, orthopnea, rales, neck vein distention, 3rd heart sound, pulmonary edema, and HJR. In their study, 36% of patients with congestive heart failure had intact systolic function by non-invasive assessment, and no differences based on clinical parameters allowed for distinction between those with normal and impaired systolic function, though systemic hypertension was more common in those with normal systolic function. They concluded that diastolic dysfunction secondary to a stiff, noncompliant left ventricle, was an important cause of congestive heart failure in up to 40% of patients with this syndrome. Likewise, Soufer, et al<sup>4</sup> found that 42% of patients with a clinical diagnosis of congestive heart failure referred to a nuclear cardiology laboratory had normal systolic function by radionuclide angiocardiology. These studies indicate that even skilled cardiologists are unable to distinguish between patients with normal and impaired systolic function who present with congestive heart failure.

The classic picture of congestive heart failure is that of a left ventricle that falls into a low-output state, secondary perhaps to myocardial ischemia and/or infarction. To compensate the heart dilates, enhancing stroke volume by means of the Starling mechanism and resulting in fluid retention. The improvement in cardiac output comes at the expense of higher left ventricular filling pressures and the potential for pulmonary congestion. Inotropic agents are effective in treating congestive heart failure due to systolic dysfunction by their ability to shift the Starling performance curve of the failing heart upward, while diuretics work by moving the heart along the same performance curve to a lower filling pressure, thereby clearing pulmonary congestion. In contrast, diastolic heart failure is characterized by a shift from a normal cardiac performance to a much steeper curve on the Starling diagram, reflecting the disproportionately high filling pressures required to maintain cardiac output from a poorly compliant ventricle. The steepness of the performance curve in diastolic dysfunction implies limited volume tolerance,



and a very narrow range between low cardiac output from inadequate filling pressures on one hand and pulmonary edema on the other. The therapeutic usefulness of diuretics in treating congestive heart failure secondary to diastolic dysfunction is complicated by the ease with which the cardiac performance may be impaired, and inotropic agents may actually worsen cardiac performance in the already stiff, non-compliant left ventricle. This could account for the fact that digoxin is of limited usefulness in some unselected patients with congestive heart failure<sup>5</sup>, since many of those patients likely have diastolic dysfunction.

Diastolic dysfunction of the left ventricle may be caused by a variety of pathological processes. Classically, infiltrative diseases of the myocardium or idiopathic hypotrophic cardiomyopathy have been thought of as likely etiologies of diastolic dysfunction. Such cases are quite rare, and the fibrosis and hypertrophy which may occur in hypertensive cardiovascular disease is much more common. Age-related changes in myocardial function may explain the relatively high incidence of diastolic dysfunction as a cause for congestive heart failure in the elderly.<sup>6</sup> Most commonly, patients with left ventricular diastolic dysfunction have underlying hypertension or ischemic heart disease, and frequently systolic and diastolic dysfunction coexist.<sup>7</sup>

A number of methods of assessing and quantitating diastolic performance have been used. Measurement of the rate of fall of left ventricular pressure during diastole and the time constant of relaxation require the use of invasive micro-manometer-equipped catheters. Indices of abnormal left ventricle filling, as may be seen in diastolic dysfunction, can be derived non-invasively from M-mode and Doppler echocardiography as well as through the use of radionuclide angiography. However, both invasive and noninvasive techniques are difficult to standardize, and are affected by loading conditions, heart rate, and age.<sup>8</sup> Practically speaking, the diagnosis of diastolic dysfunction currently rests on a clinical diagnosis of congestive heart failure, and exclusion of significant systolic dysfunction by echocardiography, radionuclide angiography, or cardiac catheterization. It is clear from several studies that this distinction cannot be reliably made on clinical grounds.<sup>4,9</sup>

An accurate distinction between these subtypes of congestive heart failure has obvious therapeutic implications. The usefulness of digoxin in the therapy of congestive heart failure has long been controversial, and its inconsistent efficacy may be the result of its use in unselected patients, some with primarily

diastolic dysfunction for whom no therapeutic benefit should be anticipated. Indeed, digoxin may well be considered contraindicated in patients with intact systolic function and normal sinus rhythm. Diuretics are helpful treatment modalities in both subgroups, but must be used very cautiously in the patient with diastolic dysfunction, due to the narrow range between low cardiac output due to the inadequate left ventricular filling pressures and pulmonary edema from volume overload, as defined by the steep Starling performance curve. Vasodilators likewise have limited usefulness in patients with diastolic dysfunction. Intriguingly, there are suggestions from some studies that agents such as beta-blockers and calcium channel blockers, which have negative inotropic effects, may benefit such patients by improving lusitropic (active ventricular relaxation) function. The beta<sub>2</sub> partial agonist xamoterol has shown significant promise with its ability to improve left ventricular relaxation and long-term function in patients with congestive heart failure.<sup>10</sup> Unfortunately, studies concerning clinical efficacy of beta blockers and calcium channel blockers in the treatment of diastolic dysfunction have given conflicting results,<sup>11</sup> and in the patient presented earlier, the use of these classes of drugs did not seem to provide much clinical benefit. The limited data available concerning the optimal treatment of patients with diastolic dysfunction makes generalization difficult. Suffice it to say that avoidance of digoxin, careful use of diuretics and vasodilators, and cautious trials of calcium channel blockers and/or beta-blockers in patients with impaired diastolic function are the basis of a rational approach to therapy.

In summary, congestive heart failure is a clinical syndrome recognized from symptoms of dyspnea, orthopnea and edema accompanied by physical signs including rales, jugular vein distention, and a S<sub>3</sub> gallop, and cardiomegaly with pulmonary venous hypertension or pulmonary edema on chest x-ray. While the traditional understanding of congestive heart failure has been related to impaired systolic contractile function of the myocardium, there are distinct pathophysiologic subgroups of congestive heart failure, with as many as 40% of patients presenting with the syndrome maintaining normal systolic function of the left ventricle. These patients with primarily diastolic dysfunction tend to be older and to have a high incidence of hypertension and ischemic heart disease. Although differentiation between systolic and diastolic dysfunction cannot be made on purely clinical grounds, the use of echocardiography or nuclear angiocardiology to assess systolic function allows the physician to

better understand the pathophysiology of congestive heart failure in a given patient. This is particularly important in making rational therapeutic choices, as the use of inotropic and vasodilator drugs, which are so effective in congestive heart failure due to systolic dysfunction, may actually be detrimental in diastolic dysfunction. Newer pharmacologic approaches, including the use of beta-blockers and calcium channel blockers in the treatment of diastolic dysfunction, may be theoretically sound, but remain to be proven clinically efficacious.

## REFERENCES

1. Plehn JF, Lotrin AM, Apstein CS: Life-threatening pulmonary edema due to left ventricular diastolic dysfunction. *Circulation* 1987; 76: IV, 411.

2. Dougherty AH, Naccarelli GV, Gray EL, et al. Congestive heart failure with normal systolic function. *Am J Cardiol* 1984; 54:778-782.

3. McKee DA, Castelli WP, McNamara PM, Kannel WB. The natural history of congestive heart failure: the Framingham study. *N Engl J Med* 1971; 285:1441-1446.

4. Soufer R, Wohlgelemler D, Vita NA, et al. Intact systolic left ventricular function in clinical congestive heart failure. *Am J Cardiol* 1984; 55:1032-1036.

5. Fleg JL, Gottlieb SH, LaKatta EG. Is digoxin really important in treatment of compensated heart failure? A placebo controlled crossover study in patients with sinus rhythm. *Am J Med* 1982; 73:244-250.

6. Wong WF, Gold S, Fukuyama O, Blanchette PL. Diastolic dysfunction in elderly patients with congestive heart failure. *Am J Cardiol* 1989; 63:1526-1528.

7. Kessler KM. Diastolic heart failure - diagnosis and management. *Hosp Prac (Hosp Ed.)* 1989; 24: 111-138.

8. Plotnick GD. Changes in diastolic function - difficult to measure, harder to interpret. *Am Heart J* 1989; 118:637-641.

9. Marantz PR, Tobin JN, Wassentheil-Smoller S, Steingart RM, et al. The relationship between left ventricular systolic function and congestive heart failure diagnosed by clinical criteria. *Circulation* 1988; 77:607-612.

10. Pouler H, Hanet C, Gurne O, Rousseau MF. Focus on diastolic dysfunction: a new approach to heart failure therapy. *Br J Clin Pharmacol* 1989; 28: 415-525.

11. Kessler KM. Heart failure with normal systolic function - update of prevalence, differential diagnosis, prognosis and therapy. *Arch Intern Med* 1988; 148:2109-2111.

## Term Life for Less... Much Less

They said compare, so we did.

Review these low male, non-smoker annual rates and call for quotes.

<u>AGE</u>	<u>\$250,000</u>	<u>\$500,000</u>	<u>\$1,000,000</u>
25	175*	275	500
30	175*	275	500
35	190*	305	560
40	210	340	630
45	235	385	720
50	373	635	1,220
55	525	975	1,900
60	838	1,625	3,200

All coverage is provided by companies rated A by A.M. Best Co. (Female rates lower)

Call (205) 279-8756 for quotes

H. Ben Coker III, CLU, ChFC  
Specialist in Life, Health & Disability

2835 Zelda Rd #7 Montgomery, AL 36106

\*200 minimum premium required by First International Life Insurance company



# Futures in Your Future

George Kleinman\*

As a busy physician, you may feel you lack the time or expertise to compete in the fastpaced world of commodity futures. You've certainly heard all the reasons to stay away. Commodity futures appear to be scary. You've heard of triumphs and big, big profits reaped by some investors, but you've also heard the horror stories of the many who lose.

Should you even consider this high-risk area? Does it make sense to place any money (let alone a portion of your retirement funds) into futures? Could futures as an investment ever make sense, or are they just a crap shoot?

This article covers the basics on commodities and financial futures, including commodity investment do's and don'ts, current areas that possess profit potential far exceeding traditional investments, and why you should consider investing in these areas.

Years ago it was unheard of for anyone to consider futures or commodities in a basic investment program, let alone a retirement plan. But today, many major corporations, including 3M and Exxon, find them a good investment, as do the states of West Virginia and Oregon (each of which last year placed \$100 million from their employee pension plans into the futures markets).

Investment volatility has increased, and as the stock market crash vividly illustrates, there can be extraordinary risks in a variety of more traditional investments from stocks to bonds. Many sophisticated investors believe it makes sense to invest a portion of funds in areas that offer potentially higher returns in order to offset lower returns obtained elsewhere. After inflation, the yield from money market funds and T-Bills is miniscule, and fixed-income returns

from municipal and government bonds can actually be negative in times of rising interest rates and inflation.

In recent years, the *world* has become the market. One cannot talk about government bonds without asking which government. Japanese and German government bonds, for example, have outperformed U.S. government bonds in recent years. Anyone who believes U.S. bonds are always the safest investment in the world is simply uninformed. Today, money moves internationally. It moves fast, and more of it moves in the currency and commodity markets than in all the world's stock markets combined.

In the 70s, physical assets—everything from silver to soybeans—were the big moneymakers. From 1970 to 1979, the Commodity Research Bureau (CRB) Index of Commodity Prices gained 174 %, while the Dow Jones average gained only 2 %. From 1980 to 1989 the Dow Jones Index of Stocks gained 189 percent while the CRB Index of Commodity Prices actually lost 26%. What will the 90s bring? It may once again be time to switch, to some extent at least, out of paper assets and into physical assets.

It's important to note that commodities are not what they used to be. Commodities do not only include corn, wheat, and pork bellies. Today, almost three-fourths of the action on the world's commodity exchanges involve financial products, including bond futures and options, foreign currency contracts, and stock market indices. Furthermore, in the last decade we've witnessed a globalization of the world's commodity exchanges. Most markets know no time zones.

## A Word About Risk

But you're thinking this is all very risky, right?

---

\*George Kleinman is president of the Minneapolis-based commodity trading firm, Commodity Resource Corporation (800/233-4445). He trades commodities and financial futures professionally on behalf of individual and corporate clients.



Actually, a convincing argument could be made that the stock market has become quite risky. Utilities and municipal bonds are certainly less risky, unless you happen to be the unfortunate owner of one that defaults or declares bankruptcy. High-income bonds were once the darlings of many investors who would never consider commodities. Then the bottom fell out, and those investors discovered the high-income bonds were actually junk bonds. There's risk everywhere. But, let's not sidestep the question; commodities can also be risky. Of course, there are strategies to control and manage the risks. However, investments that have the potential for bigger returns on capital are by their very nature riskier than those with lower returns.

Commodity futures and commodity options are risky for two reasons. First, they deal with the unknown. Tremendous profits were made for buyers of crude oil last summer, but not too many knew Saddam Hussein's plans before he invaded Kuwait. That's not to say it's all luck. Supply and demand can be analyzed successfully in normal markets, and certain markets become prime for a big move with limited risk. (For example, our firm made a lot of money in soybeans during the drought of '88. Did we know a drought was coming? Of course not. But we did know that the price of beans was cheap, demand good, and the market was prime for a big move if any supply disruption should occur. We assessed the risk to be reasonable. The drought simply turned what would have been a good trade into a terrific one.)

The key is this: Never place all your investments in any one area, particularly one with high risk. However, it may make sense to place a portion of your portfolio in a high-potential area. This portion could compensate for lower returns experienced elsewhere. It must, however, be risk capital—money that you could lose without affecting your lifestyle.

Commodity trading is a "zero-sum game." This means that for every dollar lost by someone, someone else gains a dollar. You might think about half the traders would win and the other half lose. But in reality, a majority lose. While on any one trade there is a winner and a loser, in the broader picture, new losers come in over time to replace the old losers. The winners just keep on trading, reaping a majority of the total profits. So how can you join the elite group of winners?

If you don't feel you have the time or expertise to trade for yourself, you may want to hire a professional trader to work for you. But first you'll need to determine if you have the temperament to take addi-

tional risk with a portion of your savings or pension. Only you can answer this question.

If the answer is yes, the next question is how much? A general recommendation is to place in futures a percentage of your portfolio equal to the annual return you expect to receive on your traditional investments. Assume you plan to receive a 10% overall return on your basic portfolio. Then consider placing 10% of your investable funds into futures. If you lost it all in any one year, your principal for the year would remain stable. (Good futures managers have been consistently able to return 25%, and some much more.) If you have a good year in the futures markets, this 10% of your portfolio could very well be your best investment.

Another approach is to place 10% with a futures manager and tell him or her to stop trading for you if your equity ever falls by half. Thus, your annual risk is equal to one-half your projected return (5% in this example). If this occurs, it's time to look for another commodity adviser. To be fair, you should give your adviser this 50% leeway—anything less is not enough. Expect equity swings when you're in the futures markets. Even the very best traders experience drawdowns that could be as severe as 25% or more in one month. If you start during a good period, your drawdowns will come off profits, and you may never need to tap into your principal. However, be prepared for the reality: principal swings will occur, and they could be sharp. Six months is a fair period to assess a commodity trader. Look for someone new if there is no sign of profit in six months or if your equity approaches half your commitment.

## Who Won't Urge Futures

Odds are your accountant, attorney, establishment financial adviser, and stockbroker would never even whisper the word commodities to you. Look at it from their viewpoint. They're aware that the returns could be phenomenal in commodities. But so are the risks. It's a no-win situation for them if they recommend futures and you lose a substantial percentage of your investment. They believe, as professional rule of thumb, that it is better to be safe than sorry when dealing in a leveraged market. In fact, many of these people don't understand leverage and are afraid of it.

Leverage is the key to risk and return. In the stock market, an investor who wants to trade in a leveraged manner (stockbrokers call it trading on margin) is required to post 50% of a stock's value and must pay interest on the remaining 50%—it's considered a

loan. In commodity futures, a trader is required to post margin (same word, different meaning), which generally amounts to just 5 or 10% of the total value of the underlying asset. Since the investor is trading contracts for future delivery, the remaining 90 to 95% is not considered a loan, so no interest is due. Because of this leverage, just a small positive move in the underlying commodity reaps big profits. However, leverage can be a two-edged sword, and a small move in the wrong direction can be equally unrewarding.

An example: One contract of soybeans is standardized at 5,000 bushels. At \$6 per bushel, a bean contract has a total value of \$30,000 (5,000 bushels times \$6), yet a speculator is required to post as margin only \$1,500, or 5% of the total. For every 1 cent per bushel rise in price, a \$50 profit is realized (5,000 bushels times 1 cent = \$50). Therefore, if the price rises by just 5%, or 30 cents per bushel, the trader is ahead by \$1,500, or 100% on his margin. However, the margin must be maintained. In other words, if the price of beans falls by 30 cents, the trader's original margin is depleted. The trader can then post an additional \$1,500 and hope the market comes back, or sell out and take the loss.

You have probably heard the story of the trader who stayed in too long, and a truck dumped 10,000 bushels of corn on his front lawn (or worse yet, a load of hogs). This is a myth. A professional commodity trader will safeguard against deliveries. Commodity brokers have numerous safeguards to ensure that those taking delivery of a commodity actually want it. (And even if a delivery slips through, it's in the form of a warehouse receipt that states, for example, the oats are stored in a facility in Minneapolis. These receipts are easily sold back into the marketplace.) There is never need to take delivery. The contracts are standardized and most are fulfilled by what is called offset. Offset means if you bought, say, 10 coffee contracts, all you need to do to meet your obligation is sell the contracts back into the market. This offsets your position. You don't need to wait for contract expiration. The difference between the purchase and selling price on the contracts determines your profit or loss on the trade.

Another important feature of commodity trading is the relative ease of going short. Going short is a way to profit on a down market. In futures, it's just as easy to make money in recession or inflation as in boom or deflation. Some stock market players find it un-American to bet on a down market. And there are restrictions against, for example, going short on

stocks in pension plans. Additionally, exchange rules state a stock trader can only sell after prices tick up (not in a declining market). The trader is required to pay out dividends and margin interest. In commodities, a trader who feels a market is headed south simply has to sell. The objective is to sell now at a higher price and plan to buy back at a lower price sometime in the future. Markets spend a good portion of time going down as well as up, and a trader who is astute enough to foresee a downturn should be able to capitalize on it.

Commodity-futures mutual funds are available, as are managed trading accounts for individuals. While major brokerage firms offer some good public funds, I recommend considering a private fund or an individual account in your name managed by a trader you trust. (The public funds' up-front and periodic fees, not present in private accounts, could significantly reduce your return. Additionally, with your own account, as opposed to a pooled fund, you'll receive statements on every trade, so you will be better able to monitor your investment.)

IRAs are not able to trade futures. However, most self-directed retirement plans do qualify. The firm you're planning to invest with will have to review your plan to see if there are any restrictions.

## Money Management Rules

Once you decide you're willing to place a portion of your funds in commodities, you should ask your futures adviser a few questions regarding his or her trading methods. Specific indicators called trading systems are closely guarded secrets, and your adviser probably won't share these with you. However, money management is as important as trade selection in a leveraged market, and all good traders follow certain disciplined money management rules designed to prevent disaster in the down periods and maintain the majority of principal to take advantage of good periods. Here are some basic money management rules any trader should follow:

- Have the will power and the courage to cut losses on the bad trades early and fast to preserve principal and reduce worry. This is the most critical rule for success and the hardest to follow. Successful commodity traders have as many (in some cases more) losers as winners. They come out ahead because they make the losses small. Leverage, the means of achieving big percentage gains, also dictates the need to set a "stop loss" (risk point) on every trade. This is the point where a trader admits he's wrong on that trade



and is prepared to exit. It should actually be placed with the broker and not just set mentally. A loss on one trade is never devastating. The trick is to leave the balance of your capital intact so you can live to fight another day. Never risk more than 10% of total equity on any one trade. (In the great majority of cases I risk less than 5% of equity, and I would only risk 10% if the reward potential for that trade was so great it warranted the additional risk.)

- Only take good (high reward-to-risk ratio) trades that have the potential to be terrific trades. If you're willing to risk up to 10%, the potential profit should be a multiple of this. For example, if a trade has a total average risk of 5%, the average profit potential should be 15% per trade. This way, you can lose on even half of the trades and still come out far ahead over time. Every once in a while the risk in a trade will be higher than projected due to unexpected market developments, but if the losses are consistently cut, windfall trades will make a substantial contribution to equity— increases of 50% or more in total equity are possible on a single trade.

## **Futures for Your Future**

Futures traders tend to think in terms of days rather than weeks or years; however, in the long run, those with the longer view will reap the greater rewards. While flexibility is important, a trader also needs to have a market opinion. To conclude, I'd like to share a sampling of some of my stronger opinions as we head into the second half of this year:

- Buy silver: Silver prices have fallen to all-time, inflation-adjusted lows as investors have shunned the metal in favor of paper assets in the past decade. As a result, many silver mines have recently been closed down, and production costs are above current market prices. The current low prices lead me to look for

investor demand to increase. And because the industry can't efficiently counter even a small demand increase (it takes months to reopen a mine), silver is set up for a price surge.

- Buy deutsche marks: In early 1991 the dollar made the sharpest three-month gain against the German mark in history. This occurred because of the euphoria over our victory in the Middle East and because of troubles in the Soviet Union that more directly affect the Germans. I am watching for this currency relationship to reverse in the second half of the year as traders focus again on the U.S. deficit and the relatively higher interest rates offered on German paper.

- Sell copper: In futures, it is just as easy to make money in a down market. Copper is one of my top two short-sale candidates for the coming months. Significant new copper production facilities are set to open in the latter part of the year, and without any new demand, copper could take a tumble.

- Sell hogs: The hog cycle has been well-documented and quite reliable over the past five decades. Basically, it says high prices lead to increased hog production, which, in turn, leads to lower prices. In mid 1991, historically high prices may lead to a price collapse once the new pig crop hits the market toward the end of the year.

- Buy soybeans: Acreage is down, and world supplies are relatively tight. The soybean market is counting on a perfect crop this season to maintain the current supply/demand balance. We may get it, but if even minor weather problems occur this growing season, soybean prices will surge.

Successful commodity trading involves diversification, good money management, and good advice. If there's a place in your portfolio for some additional risk, go where the potential rewards are high. It could very well be time for you to consider futures.



# On Bad Doctors

Michael A. LaCombe, MD\*  
*Annals of Internal Medicine*

The narrow road from Epinal to Provencheres is the most direct route and the most enchanting as well. Leaving the calm predictability of the upper Moselle, its asphalt races eastward seemingly without purpose, hardly noticing the licks and swirls of the Mortagne or the heavy warning of the chapel bells at Bruyeres. Only after St. Die does the road, now shaded on either side by the forests of the Vosges, slow to the climb ahead. Leaning first to this curve and now back into a leftward ascent, as though undecided about the sanctuary of the mountains, the road at last opens to the summit ridge and its clear views both east and west.

It was to this place of contemplation that Jean-Paul and Michel had traveled one rainy Monday night. There was a restaurant, of course. One never heads directly into the light, but rather assumes a more tangential course, with insight dealing a glancing blow. The only restaurant at Provencheres, called simply *Vosgienne*, was a treasure. From the outside it crouched hut-like, built low as it was against the wind. The light from its small-paned windows drew its guests within as does a church its faithful.

"How does he do it?" asked Michel. "This *potage Parmentier* is sheer perfection. Marie-Phillippe amazes me every time. A few simple potatoes and leeks, and he gives us this!"

"Commitment, Michel, commitment," answered Jean-Paul, slurping his soup. "Marie-Phillippe could dazzle us with his entrees and anyone but you, my friend, might then excuse an ordinary soup course. But it is not for you that Marie-Phillippe cooks his soup. He cooks for his God."

Michel turned to look at the fire in the great stone hearth. The corners of his mouth sagged. He tossed one hand, then the other, looked at his friend across from him, then back into the fire.

"But not everywhere do we find this commitment, eh? Even with the greatest of chefs, there is a danger at the destination ... What has happened to Roland, Jean-Paul? What do you make of it? I have known him my whole life, it seems. But he is a stranger to me now."

The west wind rattled the linden branches against the window panes outside. Jean-Paul assumed a tortured look and stalled for time.

"Happened? What do you mean, 'happened?' "

"Marianna and I went to Besançon 2 weeks ago for dinner. To be sure, his parking lot is more overflowing than ever—he has gone to three sittings—and the *Auberge Doubs* impresses as never before. One sees its lights from miles away. Roland has a red canopy 10 meters long at the entry-way, with red carpet, no less.

There is an initial excitement, a specialness one senses on first arriving. But, then...."

"Roland was my best friend, Michel," interrupted Jean-Paul sternly. "He and I were classmates."

"He was at the *ecole Hoteliere*?" asked Michel.

"Their best pupil in his day. Leagues ahead of the rest of us. Innovative . . . brilliant . . . daring."

Jean-Paul interrupted to direct their waiter, "The *matelote* for me, the *foie gras* for Michel. *Merci*."

"Excuse me, my friend, and do not take offense, but you would not know his greatness now. Roland has lost the stamp of Strasbourg. Oh, he is making lots of money, oui, and old man Gaertner would be proud of that, I suppose. But I cannot admire him or own to be of the same profession."

---

\*Dr. LaCombe: Oxford Hills Internal Medicine Group, 23 Winter Street, Norway, ME 04268.

Jean-Paul hesitated, then said, "I have not been to Besançon for years . . . Roland and I had a falling out. Still, he is an old friend. But ... what did you see there?"

"I saw a man without caring. I saw patrons run in and out like cattle, given no time, no pause, no consideration. I saw a machine for making money, a *terrine de volaille* made of paste and straw and little else, a *feuillete* tasteless, made only for show. I saw a man trading on the knowledge that *once* he had had three stars, that *once* he had trained in Strasbourg, that *once* he had been the most renowned chef in Alsace, in all of eastern France, that *once* . . ."

" 'Let he who is without sin cast the first stone,' " interrupted Jean-Paul.

"You compare me with Roland!? How can you say that *l'Ange* is like his . . . his ... factory? How can you insult my family like this!?" Michel was standing, pointing a finger, napkin on the floor. The small dining room grew suddenly still. Marie-Phillippe could be seen in the kitchen doorway. He knew these two. Dinner with them was never a dull affair.

"I meant none of those things, *mon ami*. I mean only that all of us, even you, could lose the way as Roland has. We all share that capacity."

Michel sat down, permitting himself to cool. The other diners resumed their meals.

"Lost his way," he said. "Well-put. Roland has lost his way."

Jean-Paul held his soup dish out for the waiter, nodded and smiled slightly to him, and turned back to Michel.

"What is Roland's reality?" he asked his friend. "How does he measure his life? By what parameters?"

Michel pondered the question. He turned to reflect upon his own reality. At an adjacent table sat a young family of four, parents attentive, children wide-eyed, exploring the world Marie-Phillippe had created for them. The little boy, in red bow-tie, knife and fork in either hand, confronted his *cuisse de grenouilles*, planning his attack. His sister, younger still, held the empty shell of an *escargot* aloft, as if to coax forth one last snail. Michel felt the harmony of these four, sensed their health and vitality, knew the happiness they would gain from this togetherness, advanced in some small way by Marie-Phillippe's *ambiance* and gift of perfection. At a corner table, discreetly tucked away, sat the young lovers. Every dining room has them, and every *maître d'*, the responsibility for their correct situation. Michel had watched them started on proper course, guided ever so gently away from the

expensive champagne and toward a more palatable—and more affordable—pelillant Vouvray. She, with charming *douceness*, hangs on his every word. He, strong and bold, paints the air with his gestures as he tells her of the world. Then, a pause, their eyes meet—she looks down, smiles demurely. He takes her hand.

And at the table by the fire, Michel watched an elderly couple, bathed in the hearth's amber glow, themselves holding hands, talking gently. Directly and full to the face, they behold each other, permitting Michel—and anyone—to see the love and understanding between them .

Who are these people? wonders Michel. Are they customers with fat wallets to be emptied? Strangers with dull palates to be scorned? Or something more? What do these people mean to Marie-Phillippe? And what is his place in their lives?

Finally, Michel turned back to his friend, who had been quietly observing him, and asked, "What was it you said?"

Jean-Paul smiled and said, "I asked you what you thought Roland's reality might be. From what does he derive his identity? How does he define himself in relation to his world? What is important to him, what is *veritable*?"

Michel shifted in his chair, tossed his hand in the air, pinched the wax on the candle, looked about, frowned, scowled, raised his eyebrows, and shrugged.

"The obvious things I would suppose. Money...success...power. His station in life. That, I suppose, is Roland's reality."

"Yes, those goals most compelling...arresting...intoxicating. You remember Odysseus. He lashes himself to the mast, so compelling is the Siren's song. So tempting to all of us. But the song was not always so compelling. Which of us started school with thoughts of 'I will do this thing to make money. I will learn the intricacies of my art so that I may be famous. I will become a great chef so that I may be loved, so that I may be all-powerful, so that I may be redeemed.' Do any of us as young students even *consider* these things? Of course not ! Only later, after the battle, when we think the war safely won, when we sail home on calm seas, do we hear the Siren's song. I will tell you Roland's story."

Jean-Paul turned in his chair, stretched and crossed his legs, swirled and sniffed his *gewurztraminer*, and sat abruptly upright once again. An immense sadness overtook him.

"Did you know that Johann Sebastian Bach wrote and performed only for the glory of God? He was like



our friend here," said Jean-Paul, nodding his head toward the kitchen and Mane-Phillippe.

"Roland's reality, that of ambition, never occurred to Bach. Never did Bach say to himself, 'I will compose *Toccata and Fugue in D* and become rich and famous.' Bach's reality embraced other, higher ideals. Not so, Roland's.

"Roland began modestly enough after the university, as a *sous-chef* in Marlenheim. But Roland always had one eye toward advancement. That was primary. He must make it to a one-star, then *sous-chef* at a two-star, and so on, until he is owner, with his own stars, and so forth. Always he would think, 'When I make to the next step, I will be happy, and I will have more money and more things and that will make me even happier.' Roland's ambition was like the university professor's, who forgets he exists for his students, and rather is forever planning his next career move, his next promotion.

"And of course, happiness never comes. There is always the next move, and more money to earn...no end to it. Roland imagined a treasure chest to be filled for him by life and by his own ambition...with this treasure, he would find happiness and a sense of accomplishment. He never found them, of course; the chest can never be filled. One must look elsewhere. But Roland cannot. He is trapped in this thinking, caring not at all for his patrons, always surrounding himself with more glitter.

"Friends are brushed aside, excellence forsaken, as he pursues this Siren's song. He cannot get off this path."

Michel coughed, as though to interrupt. He began carefully, not wishing for a scene from Jean-Paul such he himself had caused moments before. He began, "Each of us, *mon ami*, writes his own story, don't you think? Whatever his past, whatever it is that drives him now, do you not suppose that Roland could change? To change paths now would be difficult for him, I admit, especially with his present path so paved in gold . . . but not impossible."

"Better to start young," answered Jean-Paul, "at university or even before. Choose a higher goal, an *Ideal*, and let nothing stay your course. Perhaps it will be the thirst for knowledge or some grand creative fire within. You, Michel, have your love of people, your sense of harmony to steer you. Marie-Phillippe, his God. And my *pension*, with its *ambiance*, is an expression of the love between Yvette and myself, I suppose. We are lucky. We are this way almost by accident. Roland is not so lucky."

"Providence, perhaps," said Michel. "But we make

choices all the time, and those choices are conscious as a rule. I will bore you I know, but I am reminded of a story from *Le Rouge et le Noir*."

Jean-Paul laughed loudly and slapped the table. Michel was forever quoting his Stendhal. Michel continued, "The hero, Julien Sorel, has an affair with the beautiful wife of his employer, whose children he tutors. He then gains a position in the seminary at Besançon where he studies for 14 months. But he is compelled to return to her, to recapture what he has had with her.

"She, Mme. de Renal, has meanwhile returned to her faith in God, begging forgiveness for her past sins. With a ladder, Julien gains entry to her bedroom from the garden. She is shocked, appalled, scandalized! With renewed passion, with his awakened love, Julien attempts an embrace. Mme. de Renal rebuffs him. He pleads, he professes his undying love for her. Still she refuses.

"Then, my friend, he makes his choice. And it is fully a conscious one. He feigns a bitter remorse. He tells her (with a cold heart) of his unhappiness at the seminary, of his endless dreaming of her. Finally, he plays his last card in this game: He is leaving her forever, he says, going to Pans at once and forever. He will never see her again. He moves to the window, to the ladder, as though to leave. Mme. de Renal can no longer resist. She throws herself into his arms.

"And here Stendhal says a very moving thing, in this chapter he calls 'Ambition.'" (Michel was standing now, pointing his finger upward in instruction. The entire dining room sat in rapt attention.)

"Stendhal writes, 'Coming a bit sooner,'—that is, in response to the earlier genuine emotion from Julien— 'Coming a bit sooner, this reversion to tender feelings, the disappearance of Mme. de Renal's remorse, would have meant divine happiness; thus obtained, by art, it was nothing more than a triumph.'"

As Michel began to sit once again, the little girl at the next table clapped chubby hands. With a grand sweep of his arm, Michel bowed deeply in her direction. She smiled at him with dancing eyes.

"What begins as some strange calling, or a mother's wish, or a dream, may end, if we are not careful, in a Faustian bargain," said Jean-Claude. "It is time to go...did you smell the mangoes in this Sauternes?"

The storm had passed. Out in the parking lot of the *Vosgienne*, the two friends paused for a moment of star-gazing.

"Tell me their names again."

"Look this way then...the brightest first, there...yellowish...*Arcturus*. Hippocrates made much

of its influence, believing that illness falling under its sign would prove critical indeed. To its left...see the gentle arc of stars and its brightest at the center...*Alphecca* to the Arabs...but for certain American Indians—the Shawnee—she was the wife of White Hawk, our *Arcturus*. All is harmony, *n'est-ce pas*? Now, my friend, above *Arcturus* and slightly to the right, that beautiful star seemingly alone...*Cor Caroli* ...the Heart of Charlemagne...a French star of course, of unparalleled beauty, *naturellement*.

"Far below *Arcturus* and to the right...the very bright one...*Spica*, it's called. Draw a line between the two and to the right of your line, in that empty

space there, well, not empty really...that is *The Realm of the Galaxies*...hundreds of them, thousands perhaps, many of them French, no doubt. *Spica* is in *Virgo*, or Persephone, the daughter of Demeter, which is a wonderful story in itself..."

Thus did the two friends lose themselves in the Universe, leaving the gears of the galaxies to grind as They will.

*Annals of Internal Medicine*. 1991;114:1054-1056.

---

## ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

---

ALABAMA—EM career opportunities available in Birmingham, Boaz, and Valley, Alabama. ED volumes range from 12,000 to 30,000 visits annually. For more information please send your CV to Lynda Holland, Coastal Emergency Services of Birmingham, Inc., One Perimeter Park South, Suite 430 N, Dept. SS, Birmingham, AL 35243 or call toll free 1-800-878-4210.

---

EXCELLENT OPPORTUNITY exists for a Board Eligible Internist to join two Board Certified Internists, located near Baptist Medical Center of Montgomery. Desire availability between July 1, 1991 and July 1, 1992. Please contact - Montgomery Medical Associates, P.C., 1301 East South Boulevard, Montgomery, Alabama 36116. (205)288-7615.

---

1991 MERCEDES 500 SL, Black on black. Never driven. Purchased as a speculation car. Jon H. Widener, M.D. Office Phone: (205)749-5041.

---

NATCHEZ, MISSISSIPPI—Full-time and part-time positions available in low volume ER (less than 15 patients per day!) Flexible scheduling consisting of 12 to 60 hour shifts makes for a pleasant lifestyle. Paid malpractice insurance with unlimited tail coverage and benefit package available. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 9, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

---

FPs and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

---

ER PHYSICIANS NEEDED for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

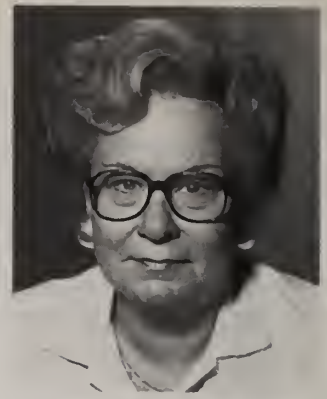
---

EMERGENCY ROOM and AMBULATORY CARE PHYSICIANS—PHP HEALTHCARE CORPORATION, a leader in healthcare management services, has a potential need for physicians to staff an emergency room & ambulatory care clinic in Millington, Tennessee (Memphis area). PHP provides paid malpractice insurance and excellent compensation. If interested please call or send CV to: Leigh Robbins, PHP Healthcare Corporation, 7044 Northridge Drive, Nashville, TN 37221, (615)662-1310. EOE, m/f

---

PHYSICIAN OPPORTUNITIES—PHP Healthcare Corporation, a leader in healthcare management services, has a potential need for physicians to staff primary care clinics located in Savannah and Columbus, GA, Charleston, SC, Fayetteville and Jacksonville, NC. We also have positions for MEDICAL DIRECTORS. Our company offers an outstanding pay incentive plan, paid malpractice insurance, and a pleasant work environment free from on-call coverage with flexible scheduling arrangements. If interested, please call or send CV to: Leigh Robbins, PHP Healthcare Corporation, 7044 Northridge Drive, Nashville, TN 37221, (615)662-1310. EOE, m/f





*Mrs. Stuart K. Bean  
A-MASA, President*

## Guatemala/Medical Auxiliary

Being a doctor's wife often requires "going the extra mile," but for two Alabama medical auxiliary members supporting their spouses has led them to Guatemala. Their story began in 1976, when a missionary nurse seeking drug samples for her rural clinic in far western Guatemala first appeared in the pediatric office of Dr. Art Stamler. Since then he and his wife, Lee, as well as Dr. Gene Bradley and his wife, Annie, have traveled to Guatemala on several medical and humanitarian trips.

The Bradleys and the Stamlers have found time in their busy lives for a group called Partners of the Americas. This non-profit organization pairs states in the United States with a country in Central America or the Caribbean. Alabama is paired with Guatemala, a Central American country just south of Mexico and north of the Panama Canal Zone.

According to Lee Stamler, they met many individuals in Guatemala who were in great need. One was a young woman who had lost a large part of her hand in an industrial accident. Another woman had a congenital heart defect. A policewoman was left paraplegic following a gunshot wound. In these instances the patients were brought to the United States for care. In other instances, medicine has been sent to Guatemala for particular problems including leukemia and nephritis. Over the years a clinic has been given equipment with money raised within the medical auxiliary as well as assistance given to a residential facility for the disadvantaged, aged and retarded.

Lee describes Guatemala as a "strikingly beautiful country that is mired in poverty and molded by the

lingering effects of colonialism." She and Art's early interest in pediatric care quickly expanded to include physician exchanges, lectureships and rural village self-help projects.

Gene and Annie Bradley became involved in student exchange programs when invited by Art and Lee to visit Guatemala in 1979 with a group of about 50 others from the Decatur area. From this visit Annie and Gene, who is a family practice physician in Centre, accepted the challenge to provide bed, board and tuition for a worthy student from Guatemala.

As a result "Tico" Herrera moved to Alabama in 1980, staying with the Bradleys and attending language institute at Gadsden Junior College. After graduating junior college and staying 2-1/2 years with the Bradleys, Tico moved to the Stamlers because he wanted to attend the University of Alabama. He has since received bachelor's degrees in mineral engineering and petroleum engineering and is now working on a master's degree.

Annie and Gene also opened their home every November for five years to a deserving high school graduate from Guatemala who stayed 3-1/2 months with them. She relates that her first visit to Guatemala included taking discarded firemen uniforms, as well as medicine and clothes, to partner cities. "No one can explain the feeling to look on the faces as they tried on those uniforms," she recalls.

Art and Lee's dream is the construction of a pediatric hospital for this region of Central America. According to Art there is no children's hospital on the



**Art and Lee Stamler**

scale of those in the United States in all of Central America. Major pediatric problems can not be resolved in Guatemala and require that patients have enough money to seek treatment in the U.S., Mexico or Europe.

Hospital care in Central America is desperately underfunded, according to Lee and Art. In Guatemala's national hospital system, for instance, the government attempts to operate each hospital bed on about \$1200 annually. This includes medication, salaries, clinical care, food and administration. Poor physician distribution and a population that does not understand basic health and sanitation needs add to the problems faced by groups working with Partners of the Americas.

Lee has also worked with groups such as the medical auxiliary to promote the manufacturing and export



**Gene and Annie Bradley**

of Guatemalan textiles. Such economic self-help programs are a goal of Partners of the Americas. They also organize exchanges between partners to learn cultural habits, ideas on education, business experiences and anything to help the partner.

Dr. and Mrs. Stamler and Dr. and Mrs. Bradley have invested their time, money and experience in improving conditions in Guatemala, and Annie Bradley says the "love affair with Guatemala is still very strong."

Both physicians are currently practicing medicine. Annie Bradley is active in the local and state Democratic party and the local Early Childhood Development Board. Lee Stamler continues to be active in the medical auxiliary and encourages economic self-help projects between Guatemala and Alabama.





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association

# Retirement Planning Needs

*AMA Investment Advisers\**

Recognizing the need for retirement planning is easy, but deciding upon the best course of action is not always so obvious. As a business owner (self-employed or incorporated), you have a range of alternatives available through AMA Investment Advisers. Choose from a number of retirement plans and related services to help secure you and your employees' financial future.

Through AMA Investment Advisers, you can adopt a qualified retirement plan that provides a host of benefits for you and your business:

- Contributions to a qualified retirement plan are tax deductible for you and your business. Earnings also accumulate within the plan free from current taxes until they are withdrawn at retirement. So you can reduce current taxes while planning for your future. (Note: Distributions from a qualified retirement plan received before age 59 1/2 are generally subject to a 10% tax penalty in addition to ordinary income tax.)

- AMA Investment Advisers offers a range of investments to help reach the goals established for all plan participants. To benefit from diversification and professional management, participants can use the AMA Family of Funds to invest their plan assets. Or they can self-direct their account by using AMA's MoneyMaster brokerage account. This account provides a wide array of investment choices, such as CDs, stocks, bonds, government securities and more. Our Financial Counselors can help participants consider all options.

- Setting up your plan is easy. AMA Investment Advisers provides prototype documents that have been approved by the IRS. We also provide amendments to the plan at no cost to you if tax regulations change.

- o Financial security for you and your employees. A qualified retirement plan is the ideal way to accumulate funds for your financial future. Eligible employees who are 21 or older and who have satisfied minimum service requirements must also be included in your plan. Contributions are usually allocated to employees in proportion to their salaries.

- Plans designed with your needs in mind. AMA Investment Advisers lets you choose the retirement plan that best matches your business's objectives.

Consider alternatives such as a prototype Profit Sharing, Money Purchase or Simplified Employee Pension plan.

In addition to these basic plans, AMA Investment Advisers offers specialized retirement plans designed to meet the individual needs of your company. For example, you may prefer a plan that includes restrictive coverage provisions, graded vesting schedules or Social Security integration. (Alternative adoption agreements are available upon request.) We have a solution to meet your needs—whether your company is big or small, a sole proprietorship, a partnership or a corporation.

The prototype Profit Sharing Plan is designed for the business owner who wants a flexible solution to the challenges of saving for retirement. Using this plan, your business can contribute a portion of profits to the retirement fund, and benefits are distributed to eligible employees as outlined in the plan's benefits formula.

Each year, you have until your tax filing deadline, plus extensions, to determine the percentage of employee compensation that you would like to contribute — as much as 15%, but limited to \$30,000 for each participant. You have the flexibility to increase or decrease your contribution percentage annually. You can even skip a contribution if profits are low during a particular year.

The prototype Money Purchase Pension Plan requires that you contribute the same fixed annual percentage of employee compensation to your business's retirement plan, regardless of profits. However, contribution limits can be as much as 25% of compensation (up to a maximum of \$30,000 per participant per year).

This alternative may be attractive if you want to maximize contributions to your business's pension plan. However, you must be willing to maintain the same commitment to your retirement plan year after year. To strike a balance, some business owners adopt the Profit Sharing Plan and Money Purchase Plan and apportion their contributions between the two.

Take the first step toward achieving your future financial goals by contacting AMA Investment Advisers at 1-800-262-3863. Find out how AMA Investment Advisers, the financial services and investment counseling organization owned by the American Medical Association, can help accomplish your financial goals. Regional Office: 200 North LaSalle Street, Suite 535, Chicago, Illinois 60601.

---

\*AMA Investment Advisers, Inc. is the financial services and investment counseling organization owned by the American Medical Association. For more complete information about any of the products and services, and any relevant prospectuses detailing fees, charges and expenses offered by the firm, call our Chicago office at call 1-800-262-3863.



## An Effective Prescription for Your Toughest Financial Headaches...

# MONEY MASTER *Preferred*

Sometimes the price of success is the financial headaches that come along with it. If you're like many professionals, you may feel like you spend too much of your valuable time keeping track of your investments, expenses, and other financial matters.

Money Master Preferred is the professionally designed, all-in-one, asset management account that gives you:

- Monthly and annual statements that show you your entire financial world at a glance—including your net worth, budget analysis, investment analysis, tax information, and more.
- A variety of money market funds for earning daily income on your cash balance.
- Check writing privileges.
- Low-cost brokerage services for stocks, bonds, and other securities.
- Up to \$10 million account protection, of which \$100,000 can be in cash.
- A choice of two other Money Master accounts:  
**Money Master Standard**—for those who do not require comprehensive asset management.  
**Money Master Retirement**—an excellent choice for your qualified retirement plan.



For more complete information about the Money Master Account that's right for you, including all fees and charges, call us now at 1-800-262-3863.

### AMA Investment Advisers, Inc.



The Financial Services and Investment Counseling Organization Owned by the American Medical Association.

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be type-written, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.

# A Teenager Looks at Malpractice

Brian Caveney\*  
*West Virginia Medical Journal*

Whom do the insurance companies and lawyers think they are kidding? They have driven America to the verge of socialized medicine.

The disillusionment of the public from the grossly and outrageously exploited cases of malpractice has permanently damaged the health care industry. This has also increased both the number of malpractice lawsuits and the amount of insurance premiums for all physicians and patients. The imperfect physicians are now wary of every patient who is treated because of possible litigation that might ruin their careers, and the widespread occurrence of malpractice lawsuits has forced insurance companies to raise premiums to exorbitant levels. Overall, the lawyers and insurance companies have split the health care industry and greatly reduced the availability of the superb care America has grown to expect. This is evidenced, for example, by a 20-year low in applications to medical school while college enrollment is increasing.

During the last decade, the number of medical malpractice suits has increased exponentially. Has the quality of health care in America deteriorated to that degree? The billion-dollar research facilities, miraculous organ transplants, new pharmaceuticals, and myriad other advancements suggest otherwise. Complications that were formerly blamed on God are now accredited to physicians' negligence. An overabundance of graduating attorneys prompted the naive public to look toward the proverbial "rich doctor" as a means of income. Rarely does the physician receive any gratitude for a miraculous surgery that enables a person to walk or talk after an accident. Instead, the patient is encouraged by an attorney to file a lawsuit against the physician for a normal complication.

There have been cases in which lawyers solicited patients in the hospital to scope possible lawsuits. The patient is provided an impetus to sue by the contingency fee system offered by lawyers in which the

patient is only required to pay the attorney in victorious cases. With nothing to lose, the misinformed patient views this opportunity as a chance to win the lottery. The victimized physician is then placed at the mercy of a jury with no aptitude or expertise to judge the medical aspect of the case.

The public, attorneys, politicians, and media would be shocked if physicians developed a similar contingency fee concept. What if a doctor loses a patient and the family is not charged? However, if the doctor fixes a Heisman Trophy winner's knee and thus allows him to progress to a professional career, he collects 40% of the player's NFL contract earnings.

What if a baby is successfully delivered and the physician receives a percentage of the baby's lifetime earnings, or a multimillionaire is enabled to live by a cardiac bypass and is billed 30% of his entire estate? This is as ludicrous as the legal contingency fees whereby a lawyer receives 40% of a large settlement and the paralyzed patient only gets 60%.

The increasing number of cases decided against physicians has outrageously enlarged their malpractice insurance premiums and, in turn, the fees charged to patients. The insurance companies are forced to increase premiums to cover the losses of unsuccessful lawsuits. Some physicians in West Virginia face annual premiums above \$125,000. This has caused some physicians, especially obstetricians, to abandon their practice or to move to a state with lower premiums. It is ironic that as the lawsuits drive off obstetric physicians, the federal government is allocating money to train midwives. As we approach the 21st century, childbirth will be Little House on the Prairie—revisited.

The higher incidence of malpractice suits has also greatly diminished the number of competent physicians in rural areas, and now patients are forced to travel great distances to receive treatments they need. The high percentage of lost lawsuits prompted insurance companies to reimburse fewer and fewer medical procedures while maintaining high premiums and raising the deductibles. Does the consumer expect to pay K mart prices for a Bloomingdale fur? Obviously not, but the insurance companies are attempting this

---

\*Editor's Note: Brian Caveney is a 17-year-old Wheeling senior who was just named a White House Presidential Scholar semifinalist for being among the top 1,500 U.S. students in SAT scores. Brian is one of the state's five Foundation Scholars this year and will be attending WVU on a full scholarship. In addition, he has been selected as one of the 30 graduating high school students in the nation to participate in a special exchange program this summer where he will study traditional medicine in China.



bargaining procedure with the physicians' fees. Regardless, at least one major insurance company, WV Blue Cross and Blue Shield Inc., has been driven into bankruptcy by this turbulent cycle brought on, in part, by the litigious attorneys and patients.

Whom are the insurance companies and lawyers actually kidding? The public has been given many misconceptions and physicians have been placed in a no-win situation. The citizens who receive major settlements as a result of winning a malpractice lawsuit jeopardize the health care of the rest of the public as a result of that winning. Some top-rated physicians have become very selective in accepting or rejecting cases while some recent medical graduates have been forced to enroll in health plan organizations that corner the medical market. Therefore, the public may be subject to the lesser-trained physicians who are more likely to exhibit a true case of malpractice. This heightens the potential for major litigation and further hampers the health care industry.

America has been pushed to the limit of considera-

tion of Senator Rockefeller's first year projection of \$60 billion for the Pepper Commission's recommendations. This type of structured nationalized health care could push the U.S. into an economic tailspin. The American public should realize the intrinsic problems of a socialized medicine system that would ultimately be devised through the efforts of attorneys, insurance representatives, and government bureaucrats, all untrained in complicated modern science. The system is currently being rejected by various countries. For instance, patients in England and Wales are placed on waiting lists of up to four years for elective procedures. The top quality students will not undertake 25 years or more of rigorous education and expenses as evidenced in England and then be subjects of a bureaucratic system.

A greater public awareness is needed to recognize and rectify the damage to the health care industry in America caused by the insurance companies, attorneys, and plaintiffs looking for a big time, lottery-like win.

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

<u>MALE AGES</u>	<u>\$250,000</u>	<u>\$500,000</u>	<u>\$1,000,000</u>
25	248.00	455.00	845.00
30	248.00	455.00	845.00
35	255.00	460.00	875.00
40	298.00	545.00	1,045.00
45	348.00	645.00	1,245.00
50	430.00	810.00	1,575.00
55	600.00	1,150.00	2,255.00
60	875.00	1,700.00	3,355.00
65	1,525.00	3,000.00	5,955.00

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

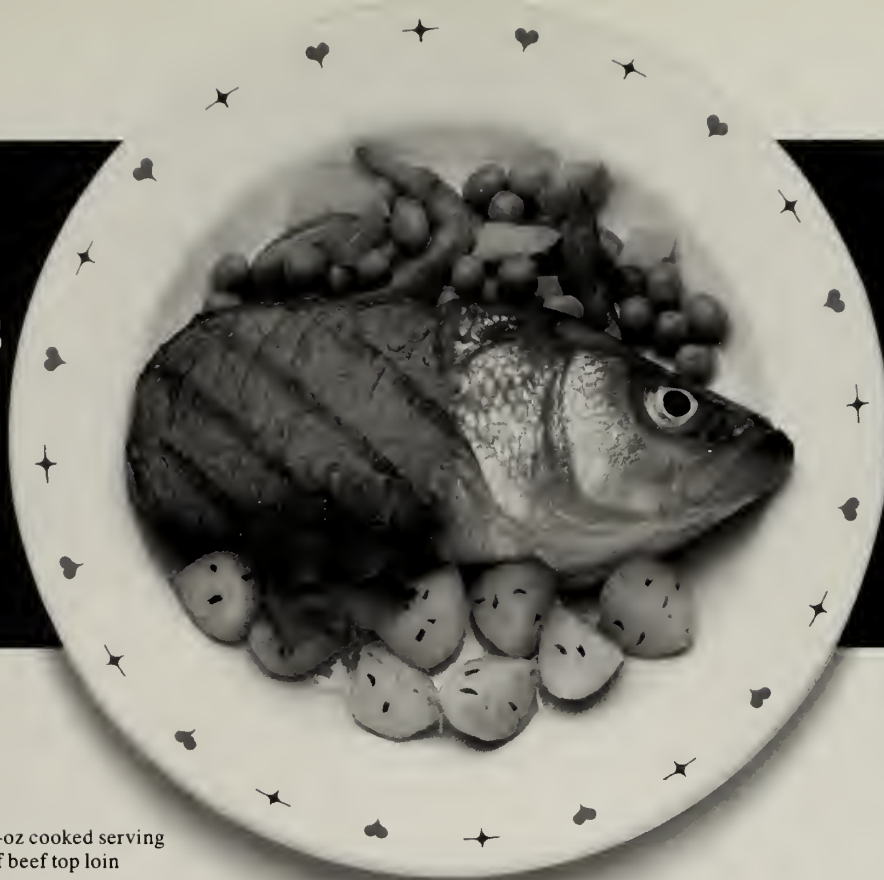
For a written quotation and policy description send your date of birth and amount of coverage desired to:

**COOK & ASSOCIATES**

P.O. Box 850517 • Mobile, Alabama 36685-0517 • (205) 341-5168

Above rates are provided by Jackson National Life

Let  
your  
patients  
know  
they  
can eat  
beef...



...as  
well  
as  
fish.

3-oz cooked serving  
of beef top loin

While fish and chicken are appropriate choices for fat-modified diets, so are lean cuts of today's beef.

The fat profile of lean beef may surprise you. And with beef's good taste and versatility, you can improve the chance of patient compliance with your dietary recommendations.

Today, beef cuts are lower in fat. According to a national supermarket survey, there is on average 27% less trimmable fat on retail beef today than in the late '70s and early '80s.<sup>1</sup> A follow-up survey in 1990 confirms a continued reduction in fat trim.<sup>2</sup>

## AHA and NCEP guidelines allow lean beef

The American Heart Association and the National Cholesterol Education Program have recognized the place for lean beef in a varied, balanced diet. Both of their dietary guidelines recommend up to 6 oz daily of lean beef and meats, poultry, or seafood.<sup>3,4</sup>

Here are guidelines that can help your patients enjoy beef that's compatible with a heart-healthy diet:

- Purchase lean cuts
- Keep portions moderate (3 oz cooked)
- Remove visible fat before cooking
- Prepare without additional fat

### References:

1. Savell JW, et al. National Beef Market Basket Survey. *J Anim Sci*. In press.
2. Morgan JB, et al. *National Beef Tenderness Survey: Meat Research Brief*. College Station, Tex: Meats and Muscle Biology Section, Department of Animal Science, Texas A & M University; 1990.
3. American Heart Association. *Dietary Guidelines for Healthy American Adults*. (Document No. 71-1003). *Circulation*. 1988; 77 (3).
4. National Cholesterol Education Program. *Report of the Expert Panel on the Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults*. Washington, DC: National Institutes of Health; January 1988. NIH publication 88-2925.

Recommend  
Today's Lean  
Beef



A Heart-Healthy  
Choice

©1991 Beef Industry Council and Beef Board

Alabama Cattlemen's Association



# A BRIGHT IDEA TO START WITH...



**180<sup>mg</sup>**  
**Calan<sup>®</sup> SR**  
(verapamil HCl) 180 mg  
SUSTAINED-RELEASE CAPLETS

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

MS

FRANKLIN A. COUNTEY  
LIBRARY OF MEDICINE  
10 SHATTUCK STREET  
BOSTON, MA 02115-0000

AUGUST 1991 Vol. 61, No. 2

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

*If you are in a  
quandary over  
the direction  
of American  
health care,  
Dr. Lazenby  
counsels,  
return to  
your root  
commitment:  
patient care*



THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

SEP 05 1991

**Page 6**

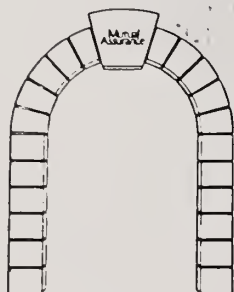


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 2, AUGUST 1991

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1991 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Myers, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Joel C. Pittard, M.D. (1992), Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*, Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Pt. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

## EXECUTIVE DIRECTOR

S. Lon Conner

Secretary-Treasurer - Emmett Wyatt

## DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

*The Seventh Age*.....2  
D. E. Gray, M.D.

Executive Director.....4  
*Simple, Uncomplicated Madness*

President's Page.....6  
*Professional Integrity*

*Physical Activity and Fitness Assessment*.....10  
Ronald A. Feinstein, M.D., FAAP, et al.

Classifieds.....14

"...We made it!" .....15  
Tommy Powell

Index.....18

*The Investment Food Chain*.....25  
James W. Mangham, III

*Working Together: PA/MD Bonding*.....26  
Robert L. Bloomfield, M.D., F.A.C.P.

*Practice Parameters Blues*.....29  
Ira Green, M.D.

Auxiliary.....30  
*Schendal, M.D., In Iraq*

THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

SEP 05 1991



# The Seventh Age

*Editor D. E. Gray, M.D.  
In Kansas Medicine*

The matter of aging has received much attention in recent years and promises to demand more before society is fully comfortable with it. Sociologically, it is a moving target, since the diversity of aging's effects confounds all but the most general solutions. Medical attention has been both voluntary and forced, and finally dignified by the specialty of gerontology. However, the process is not always a matter of destructive pathology and, as there is a significant increase in the aged group (however defined), there is an increase in such persons retaining reasonably sound health and productivity. This has led to a variety of pursuits—social, political and academic—designed to satisfy the interests of those who are capable. And there have been endless commentaries about what to do with the old folks.

The fact is that the process is not any one thing—neither an accomplished state of pathology nor a Golden Age of Personal Discovery. It is, rather, a gradual process accomplished by the incursion of increments of degeneration and malfunction that complicate previously simple efforts. This summing up sounds grim; but the point is that the process is, for the subject, often self-deniable for extended periods, resulting in friction between the individual and those observing the changes from the outside.

The measurement of a person's senility requires placement of the individual in his or her setting. Absent some specific disease state, the social and domestic circumstances are probably as much a factor in the manifestations of the aging state as wear and tear on the organism. The term "aged," in itself, sets a definitional limit which is necessarily broad, since the variety of minds and bodies so classified is extensive. But there is often an undeniable fact: the approaching (though unknown) limit of life develops in ways unrealized during earlier days of concern with other problems.

This is not a morbid reminder that death is in the offing; it is a simple awareness of that finite, but unknown, limit (and the fact that we owe more to our inherent autonomic nervous systems than to any health advisories or uplift programs). Positive thinking is fine, but an increasing focus on health mat-

ters—if not of one's self, then those of a spouse or relative or friend—is forced on most individuals. One becomes gradually (though by no means unknowingly) adjusted to a life schedule incorporating the demands of aging, and they become accepted, sometimes philosophically, sometimes resentfully.

Those working with the aging know (or should know) that, whatever the individual circumstances, it is a depersonalization process. In the words of an elderly lady, moving into a retirement complex apartment, "Now I'm just a name on the door."

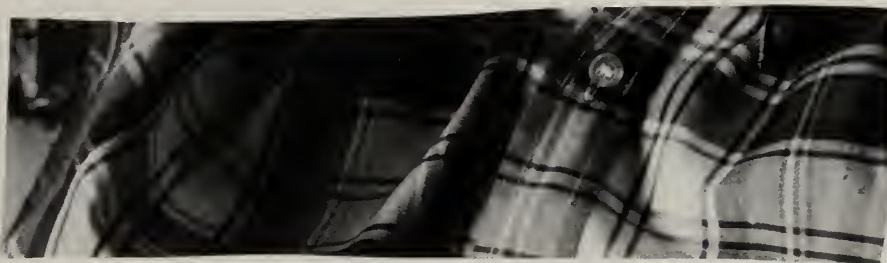
Aging is a reduction process, eternally as well as internally. The successive limits of capability (and, it can be said, need) usually require a reduction in the size of quarters, with elimination of valued mementoes. With each stage of increasing disability, there is an accompanying detachment from those connections with earlier times—and movement into a shrunken world. A form of geriatric happiness, perhaps, would be an equivalent loss of physical and intellectual capabilities, so the process of leaving the past is less traumatic.

That variety of lifestyles adopted by the aging is often the product of the variety of family circumstances obtaining. There are those in which a strong familial sense of responsibility (not to mention economics) dictates that the aged person will remain within that group. There are those who may not have such available—or know that the "live-in" arrangement is untenable. Blessed is the family where this is known and amicably accepted on both sides.

In either case, however, this may simply defer the matter since (unless mortality resolves it earlier), there is certain to come a time when closer attention is required and the prospect of some intermediary care must be faced. Increasingly, the problem becomes one of the interposition of the thoughts and feelings of others for those of the individual. There can be no stronger argument for the maintenance of informed and considerate interpersonal relationships between the generations than this, a firm basis of the desired and desirable. As gerontologists are aware, the physician's role should encompass much more than organic pathology.



*Bitter. Mad. Hateful. Disappointed. You never know what a day might bring.*



That friendly man who answers the phone at MMRC doesn't sound like the same one who showed up 16 years ago at our front door.

A tragic car wreck had left Lamar Myers a quadriplegic. And had left him some pretty bitter feelings to try and deal with.

Fortunately, he wasn't left to deal with them alone. Because the

staff at MMRC showed him that life goes on.

"Everybody was willing to work with me," he says. "All I had to do was try. My life didn't have to end the night of that car wreck."

Through months of physical, occupational and recreational therapy, Lamar gained a whole new respect for life. And the staff at MMRC never stopped caring.

It's that commitment to

rebuilding patients' lives that makes MMRC the South's leading rehabilitation center. If you don't believe it, just give our switchboard a call.

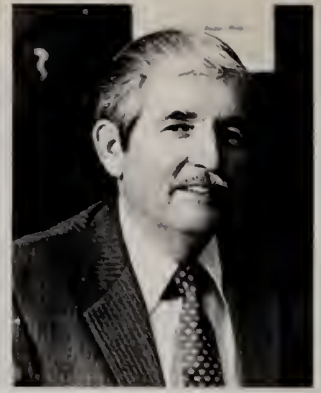
You'll hear a lot more than a simple "hello" on the other end of the line. You'll hear the voice of a friend who never said goodbye.



**MMRC**  
MISSISSIPPI METHODIST  
REHABILITATION CENTER

1350 East Woodrow Wilson, Jackson, MS 39216  
(601) 981-2611 or 1-800-223-6672





*S. Lon Conner  
Executive Director, MASA*

## Simple, Uncomplicated Madness

**A** chastened Gail Wilensky, HCFA Administrator, commented the other day that if doctors do succeed in reversing the 16% cut in the Medicare conversion factor, Congress would have to come up with the billions necessary to replace that. In other words, she made it appear that the nation's physicians were begging for a handout from the taxpayers.

Last year's budget agreement did say that if Congress wants to add to an appropriation, it is contractually obligated to make up the difference in either new revenue or compensatory cuts elsewhere.

I think Administrator Wilensky may have given the game away: rip off doctors and then hold them hostage to the demand that if they are paid what Congress had intended, then Congress would have to provide the means. No matter that Congress had expressly forbidden use of the physician payment reform as a budget-cutting tool. The Bush Administration obviously wants it to appear that greedy doctors are demanding more money, thus to fire up public outrage, when in fact HCFA broke the law in mugging physicians.

It's almost as if you are held up on the street and a cop is handy to witness the theft. Then your assailant protests to the cop that if restitution is to be made, the cop must make it from funds he must somehow raise. But there is a distinction here: real money is not involved in the \$7 to \$20 billion that would be deducted from physician services over the five-year period. At least, it's not real money yet. We're talking budget here — that is, figures that have very little basis in reality.

MASA President William D. Lazenby, M.D., in his July column, noted:

"In the smoke & mirrors of what Washington budget-balancing has become... few things are ever entered honestly on the books... The budget process, in point of fact, has become the biggest free-floating fraud in American life."

At the time he wrote this, Dr. Lazenby could not have known how right he was. In late July, Paul Craig Roberts, a former Treasury official now serving as chairman of the Institute for Political Economy, revealed in some detail how the budget deal struck between Congress and the President last fall was pure myth from the beginning—a lie agreed upon in a fine display of bipartisan conniving to keep the public in the dark.

Remember the headlines to all this: After a long hot summer of budget "summit" negotiations, President Bush and Congress cut a deal that was described as a compromise and a major concession by the President: he signed on to a \$165 billion tax increase in exchange for \$500 billion in deficit reduction. Here was George Bush, he of the "read my lips... no new taxes" pledge infuriating the Reaganomics wing of his party by this apparent about-face.

The White House told the die-hards to shut up because at long last something was finally being done about "their" deficits, meaning those brought on by Reaganomics, Mr. Roberts recalled.

Here it is just nine months later and the Administration's Office of Management & Budget has just released its mid-session review of the budget.

“Far from a five-year deficit *reduction* of \$500 billion, the cumulative deficit for 1991-95 has *doubled* to \$1.087 trillion.”

A lot of commentators are calling for the head of OMB Director Richard Darman for “the worst fiscal management in U.S. history,” Mr. Roberts notes, “but [this] charge of incompetence shields the government from the far more serious charge of fraud.” In other words, all parties knew at the time it was a hoax on the public:

“Before the budget agreement was reached, the government knew that its claim for deficit reduction would not be achieved. It withheld revised economic assumptions that showed that the recession would eat up the projected revenues from the tax increase, together with 20% of the claimed outlay reductions. Government officials, distressed at this deception, gave me a copy of the revised forecast, which I published on this page on Oct. 3, 1990.

“However, instead of facing outrage for blatant fraud, Mr. Bush was widely congratulated for his ‘realism’ in rejecting the myth that economic growth could reduce the deficit [a central dogma of the Reagan Republicans]. The fraudulent deficit reduction bandwagon rolled on, growing in outrageousness.

“To make the budget agreement look even more palatable, Mr. Darman commingled the one-time affair of acquiring and disposing of S&L assets with the taxing and spending operations of the government. In the short run, this unconventional accounting practice inflated the deficit as the assets came into the government’s hands, but the subsequent sale of the assets counted as negative spending in later years. By distorting expenditures this way, Mr. Darman was able to project federal outlays in 1994 at \$50 billion below the 1992 level, thus giving the appearance of expenditure reduction.

“Mr. Darman has managed to produce a larger deficit with a tax increase and a defense build-down than Mr. Reagan achieved with a tax cut and defense build-up. The Bush administration now forecasts a 1992 deficit of \$348 billion, much larger than the Reagan administration’s record of \$221 in 1986. Moreover, unlike the Reagan deficits, the Bush deficit

is not offset by the state and local surpluses that were part of the long Reagan expansion.... Today only Italy among major industrial countries has a larger general budget deficit as a share of GNP than the U.S....

“As the true magnitude of the budget fraud begins to come to light, those responsible are beginning to run for cover. Mr. Darman blamed the revenue shortfall on a mathematical goof by Treasury revenue estimators. Such public fingerpointing by one administration department on another suggests that more shoes are due to fall.

“Indeed, an even bigger deficit may be on the way. Government officials are speaking of a ‘January surprise’ when the budget is released. They are worried because of their discovery that the tax-base share of GNP appears to be shrinking.”

These and other markers point to only one thing that the politicians can’t even embolden themselves to look at — “A dying economy.”

This being the sorry state of bookkeeping in Washington, it would seem easy enough to answer Ms. Wilensky’s warning that a restoration of the money the Administration tried to swipe from doctors would require other cuts or new revenues. Hogwash. All that’s necessary is to simply move it “off budget,” the black hole where huge and impossible obligations are placed so nobody will have to think about them. Either that, or hand the bill to the folks trying to clean up the S&L mess — a few billion more should scarcely be noticed. The taxpayers will be paying for it forever in any case.

Seriously, I fear for my country. For so many years now, we have had these elaborate games designed to conceal the truth not only from the public but from all the principals in Washington. We have apparently decided, Republicans and Democrats alike, Congress and Administration together, that the mounting debt and the snowballing deficit are impossible to solve; therefore, horrible to look at; therefore, we won’t look at them.

Given this posture in Washington, it is any wonder that HCFA felt entirely justified in doing what it did? It was crazy, to be sure, but where is the sanity in Washington budget-making?





William D. Lazenby, M.D.  
President, MASA

## Professional Integrity

The ancient doctrine of *noblesse oblige* (“nobility obligates”) places a heavy burden on the physician. It always has, for the simple reason that in return for our license to practice medicine, we make a solemn covenant with society.

In substance, that covenant reads like this: the state grants us an enormous power over the health and the lives of its citizens, a position of the highest trust. In return for this fiduciary grant, we obligate ourselves to devote our time and talent, for life, in absolute dedication to our patients, forsaking all others.

The common translation of *noblesse oblige* is pertinent here: “Much is expected of those to whom much is given.” The license we are granted stems directly from the writings of Plato, with later ruminating by Hobbes, Locke, Rousseau and others on the “social contract.”

The social contract idea is that a sovereign, whether a monarch or a democratically elected government, owes the people its protection, in return for which the people owe that sovereign their loyalty and allegiance.

The sovereign (state) may contract out certain of its obligations, as it does to us to attend to the health of the people. But in so doing the sovereign receives from us our solemn pledge that we will faithfully and truthfully carry out our part of the bargain.

To ensure that we live up to our obligations, the state grants another major concession from its paramount powers —the contract between us and society will be monitored by our own peers through

special agencies of the government, in our case the Board of Medical Examiners and the Licensure Commission.

This delegation of sovereign authority to the profession, not only to carry out its mission but to police itself, was won after centuries of struggle by our professional forebears. It is all too easy for us, practicing here in the last decade of the 20th century, to forget what a grand privilege we enjoy.

But that great privilege always carries with it a corresponding and proportional obligation: Much is expected of those to whom much is given. In a word, each physician is guided and sustained by his own professional *integrity*.

Those among us who fail in this regard fail all of us. And the temptations to fail are all about us, now perhaps as never before. That is so because of the process, in our generation, of what has been called (by Eli Ginzberg, Ph.D., of the Columbia College of Physicians and Surgeons) the “monetarization” of American health care.

Once driven by altruism and the noble concept of service, Dr. Ginzberg argues, U.S. health care is now propelled by the dollar. In his recent book, *The Medical Triangle: Physicians, Politicians, and the Public*, Dr. Ginzberg looks back to the period before World War II to support his thesis:

“By no stretch of the imagination, nor even of ideology, could the U.S. health care system at the outset of World War II be said to have been a predominantly — and surely not exclusively— private, for-profit

enterprise....

"The surest way to delineate the magnitude of the transformation of the U.S. health care system since World War II is to note that in 1950 total expenditures came to approximately \$13.5 billion, or 4.7% of GNP." [Current expenditures approach \$700 billion and nearly 12% of GNP.]

Where did the present monetarization begin? Dr. Ginzberg:

"More by accident than intent, health care insurance as an employee benefit was vastly expanded during World War II, following a ruling by the War Labor Board that such benefits were not in violation of the wartime wage freeze."

After the war, the Bureau of Internal Revenue pronounced employer payment of health care premiums tax exempt, as were the benefits received by employees.

However, the enactment of Medicare/Medicaid in 1965 substantially increased government's share of the total health bill. As a consequence, the regulatory role of government has increased substantially over the last 30 years, even during the Reagan years, despite the official opposition to bureaucratic oversight.

Thus since the end of World War II, government and industry have evolved into the dominant payers of medical bills—together accounting for some 70% of all payments. Broken down another way, government accounts for about 42% of total expenditures, the remainder being provided by consumers and employers in about equal proportions.

In the past decade, the cost of health care has skyrocketed, the inevitable result of increased demand stimulated by government buying, quantum jumps in ever more expensive technology, an aging population, and, importantly, the insatiable appetite of the public for more and better of everything.

Together, government and industry constitute what economists call a "monopsony," market control by one or more major buyers — as distinguished from monopoly, market control by one or more major sellers. For a time, both the public and private sectors contented themselves with eliminating waste; now both have turned, in a variety of camouflaged ways, to rationing as a cost containment strategy.

In the resulting national hue & cry, physicians make easy targets for cheap shots. Americans more than any people on earth always make it the first order of business to find somebody on which to blame any accident, dire predicament, whatever. (For example, after 50 years, we are still debating the iden-

tity of the villains who allowed Pearl Harbor to happen.)

With such a national mindset, physicians have become targets of opportunity. The general public is bored by the responsibility of the laws of supply and demand, or the fact that Americans always want the best and the most of everything, particularly if it's "free."

CT and MRI scanners, the cold and immutable laws of economics — none of these make proper scapegoats. People want to blame people and you, doctor, are it. You wear a white hat to your patients, but that becomes a black hat when the public looks at all of us collectively.

Chagrined, hurt and at times more than a little angry, some physicians seek revenge against the system, almost as if they are saying, "If it's a greedy doctor they want to find, someone interested only in money, then that's what they'll get."

That reaction may be understandably human, but it is certainly not integrity. Integrity implies the moral stamina, the guts, to take all they can throw at us and still keep our focus on patient care, serenely confident that nothing really matters but this, which is what we all signed on to do.

Nobody promised us a rose garden, a professional life free of vexation and exasperation. I don't remember receiving any money-back guarantee that my training would automatically make me a folk hero, do you?

Concentrate on being the best doctor you can be for those who depend on you and let politicians and celebrities worry about popularity polls. In all your dealings, professional as well as public, your word should be your bond.

It goes without saying that you should maintain the highest moral standards in all aspects of daily life. The physician of integrity will not take advantage of patients; he/she will not gouge; or abuse the position of trust in any manner whatever.

Remember the acronym WALT: Walk like a doctor; Act like a doctor; Look like a doctor; Talk like a doctor. If all 600,000 of us did these simple things in addition to devoting ourselves to patient care as our paramount concern in life, do you really believe we would have an "image" problem?

Seek your fame, if fame you must have, among your patients. If to them you are the epitome of excellence and caring, what does it matter that Teddy Kennedy and Pete Stark are badmouthing you? The quietly confident and dedicated physician, the doctor of integrity, will always find his reward, indeed his



For excellent response in the treatment of  
duodenal ulcers...

# **AXID**<sup>®</sup> nizatidine has the right answers

- Rapid epigastric pain relief<sup>1,2\*</sup>
- Fast and effective ulcer healing<sup>2,3,4</sup>



**AXID**  
**PASSES THE ACID TEST**

\*Most patients experience pain relief with the first dose.  
See adjacent page for references and brief summary  
of prescribing information.

**AXID®** (nizatidine capsules)

**Brief Summary:** Consult the package insert for complete prescribing information.  
**Indications and Usage:** 1. Active duodenal ulcer—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. Maintenance therapy—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests:** False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions:** No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 60 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterocromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodule hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C:** Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:** Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use—Safety and effectiveness** in children have not been established. **Use in Elderly Patients:** Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic—Hepatocellular injury** (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L). The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular:** In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS:** Rare cases of reversible mental confusion have been reported.

**Endocrine:** Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic:** Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental:** Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity:** As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other:** Hyperurcemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP  
[091190]

**References**

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request.



**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

heaven on earth, in the faces of those who turn to him for care and comfort.

Since there is no other reward worthy of mention, neither can there be any need for artificially generated "image" and "prestige." We knew this, didn't we, when we accepted the pluses and the minuses of *noblesse oblige*? We knew that the grail we sought was not the same as that pursued in the world of commerce and finance.

Had we sought a life of ease and riches, medicine would not have been our choice. What we do is the most spiritually fulfilling of all human labor. How can we be depressed?

Let me close by calling to your attention to the inaugural words in June of the new President of AMA, John J. Ring, M.D., a family physician from Mundelein, Illinois. Calling for a rededication of the American physician to the ideals of his historical roots, Dr. Ring said:

"It's time to prove to America, in deed as well as word, that we are a doctor's organization, working for the good of our patients, rather than a pressure group aiming for political power as a way to build organizational predominance, to create personal prestige, or to line our own pockets."

Physicians, he continued, can accept nothing that threatens to turn medicine into a "mere trade, a dispassionate business venture, an impersonal public utility." Physicians can accept nothing that maneuvers them into working for anyone other than their patients. They can accept nothing that asks them to ration needed care.

"As we willingly sacrifice for the good of our patients," Dr. Ring concluded, "we gain in public esteem." He urged physicians to "choose the road that keeps American medicine on the mortal high ground."

At this point in history, I can think of no wiser advice to the American physician, advice more crucial to our preserving the grand tradition that was the reason, one way or another, all of us were called to the profession.

Remember this: we do not own medicine, but hold it in trust for succeeding generations of doctors and patients. There can be no greater obligation or larger reward than ours.



# Physical Activity and Fitness Assessment

*Ronald A. Feinstein, M.D., FAAP\**

*Kennon T. Francis, Ph.D.*

*Christopher Lorish, Ph.D.*

## Abstract

Physical inactivity is a risk factor for the development of atherosclerosis. Members of a state chapter of the American Academy of Pediatrics were assessed about their practice behaviors and knowledge related to physical activity and fitness assessments. During health supervision evaluations 19% obtained a physical activity history and 7% measured a heart rate response to exercise. When assessing physical fitness 24% obtained an activity history which included kind, intensity, duration and frequency. 64% limited their physical fitness evaluation to an inspection of general appearance and weight, while 1% used a bicycle ergometer or treadmill, 4% used a step-test and 10% ran a child in place. Only 42% used the information to make recommendations about physical activity. 75% were not familiar with ACSM or AHA recommendations about exercise. Barriers cited to increasing physical activity and fitness assessments included lack of physician time, office space, staff time, and physician training. This survey demonstrates the need for increasing the awareness level of pediatricians about the role of exercise in preventing CHD and the need to incorporate such evaluations into their routine practice.

## Introduction

Coronary heart disease (CHD) due to atherosclerosis is the leading cause of death in adults residing in the United States.<sup>1</sup> A number of risk factors have been identified that are known to be associated with the development of CHD in adults.<sup>2</sup> Several of these risk factors including hypercholesterolemia, hypertension, cigarette smoking, obesity, and a sedentary lifestyle oftentimes have their origin during childhood

or adolescence.<sup>3-6</sup> Of these risk factors, recent research has shown that among adults physical inactivity is one of the more important modifiable risk factors related to the development of CHD.<sup>7-9</sup> Since most patterns of physical activity are established early in life,<sup>10</sup> it seems evident that interest in youth fitness should be an important component in the provision of health care services to children and adolescents.

The National Children and Youth Fitness Study<sup>11</sup> provided data showing that "American children are not achieving the lifetime fitness skills required to promote good health." Physical activity patterns of children in the United States demonstrate that children become less active and likely less fit with increasing age.<sup>11</sup> One reason for this problem might be that pediatricians do not advise young people and their families about the risks associated with physical inactivity nor about the benefits associated with being physically fit.

It is possible that a reduction in the development of CHD can be attained by early identification, intervention and modification of risk factors such as physical inactivity among children and adolescents by pediatricians. Presently recommendations for a comprehensive evaluation of fitness and physical activity patterns, with guidelines for exercises and protocols for counselling, have not been established for children or adolescents. Before these can be developed there is a need to determine the present level of awareness and practice behaviors regarding physical fitness assessments by pediatricians. The purpose of this pilot survey was to assess practice behaviors related to physical fitness assessments of children and adolescents by pediatricians.

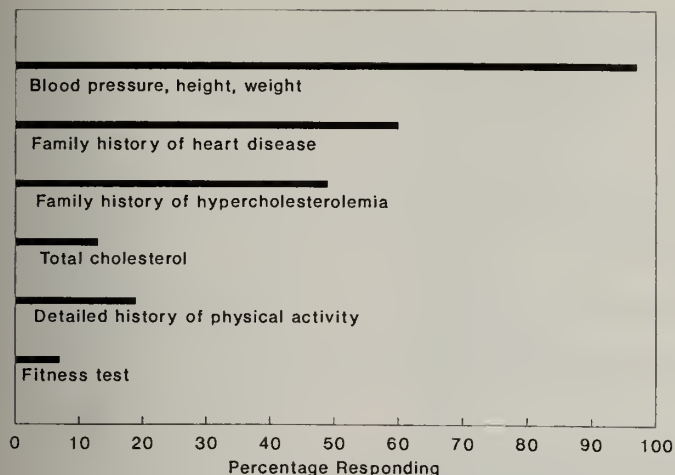
## Methods

During the fall of 1990 a Physical Fitness and Activity questionnaire was mailed to all (n=349) members of the Alabama Chapter of the American Academy of Pediatrics. The questions were designed to elicit information on the practice behaviors related to the assessment of physical activity patterns and

---

Mailing address: Ronald A. Feinstein, M.D., Associate Professor, Department of Pediatrics, Division of Adolescent Medicine, University of Alabama at Birmingham, 1600 7th Avenue South, CHT-157, Birmingham, AL 35233

## Risk Factor Assessment



**Figure 1:** Percentage of pediatricians performing risk factor assessments during Health Supervision Evaluations.

physical fitness levels of children and adolescents six to eighteen years of age by pediatricians. All questions were formatted for multiple-choice responses and were pretested with a group of pediatricians to establish clarity, sensitivity, and specificity. More than one response was possible on many questions. None of the physicians participating in the development of the survey tool or the evaluation were included in the data analysis.

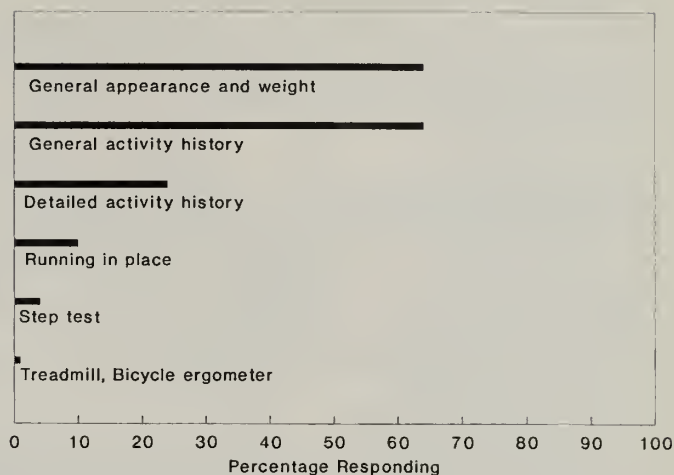
### Results

One hundred and thirty-six of the questionnaires were returned completed within two weeks of the mailing for a response rate of 39%. Sixty-five percent were received from pediatricians and 6X were returned from family practitioners. Twenty-nine percent of the questionnaires returned came from physicians who did not specify their field of practice. The final sample had the following characteristics: men, 61%; mean age 45 years; average time in practice 14 years. Fifty-one percent of the respondents participated in a group practice with two or more practitioners. Nineteen percent of the practitioners had solo practices while 11% worked at a Public Health Clinic.

Nineteen percent of the respondents did not specify their type of practice. Sixty-seven percent of the respondents reported an average daily patient census of 26 to 50. Thirty percent saw less than 26 patients per day while 3% saw more than 50 children a day. Data is not available from the Alabama Chapter of the American Academy of Pediatrics describing the composition of the total membership relative to the demographic factors acquired in this survey.

There existed a wide range of differences between the percentage of times individual coronary heart dis-

## Method of Determination of Fitness



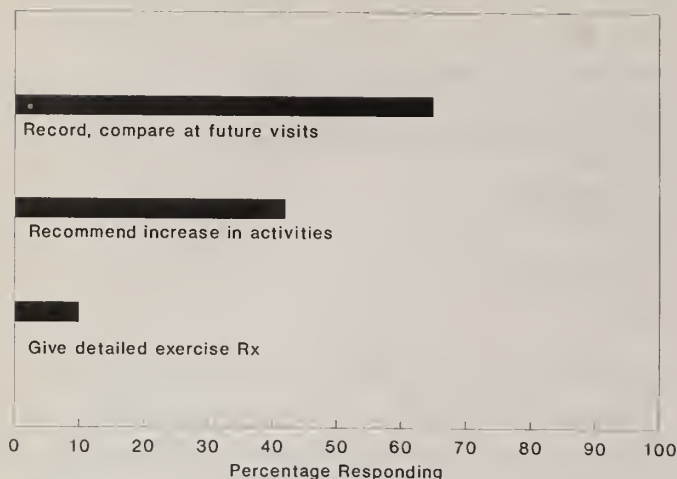
**Figure 2:** Percentage of pediatricians utilizing various means of determining physical fitness.

ease risk factors were assessed by respondents during health supervision examinations (HSE) of children and adolescents 6 to 18 years of age (Figure 1). Blood pressure, height, and weight were measured during 97% of the HSE. A family history of heart disease was obtained by 60% of the respondents while a family history of hypercholesterolemia was acquired 49% of the time. A total cholesterol, a detailed history of physical activity, and a fitness test, which included measuring a heart rate response to exercise, were only measured routinely by 13%, 19%, and 7% respectively of the respondents.

Objective physical fitness measurements were rarely obtained by respondents (Figure 2) when determining physical fitness. Sixty-four percent of physicians limited their evaluation to an inspection of general appearance and body weight and a general, non-detailed exercise/physical activity history. Only 24% of the respondents obtained a more detailed physical activity history which included a determination of kind, intensity, duration and frequency of physical activity. Never was a one-mile or a distance run used to assess fitness. One percent of respondents used a bicycle ergometer or treadmill, 4% utilized a step-test, and 10% had a child run in place to assess physical fitness.

Figure 3 shows what physicians did with the information they obtained related to physical fitness. Sixty-five percent of respondents limited the use of the information to recording it in their medical records to use for future comparisons. Only 42% of the physicians used the information to make recommendations to increase the duration or amount of physical activities routinely participated in by a child.





**Figure 3:** Utilization of fitness data by pediatricians that due a fitness assessment.

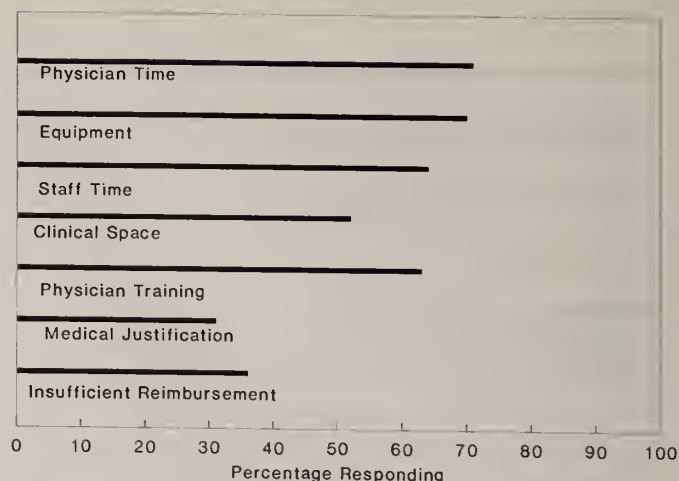
Only 10% of the respondents provided their patients with an exercise prescription that included: intensity, duration, and frequency of an activity to enable them to improve their fitness level.

Seventy-five percent of the respondents replied that they were not familiar with the recommendations of either the American College of Sports Medicine or the American Heart Association regarding physical fitness and physical activities. Figure 4 lists a number of barriers pediatricians believed were "very important" in preventing them from obtaining physical fitness data in their office. The two most frequently listed barriers cited were lack of physician time by 71% and lack of equipment by 70%. Other barriers identified were lack of staff time by 64%, lack of office space by 52%, and lack of physician training by 63% of the respondents. Only 36% of the physicians believed that insufficient financial reimbursement was a significant impediment of a fitness assessment.

#### Discussion

At the present time there is substantial evidence that supports the fact that the atherosclerotic process begins in childhood.<sup>12,13</sup> Many researchers believe that it is possible to prevent the development or reduce the risk of CHD in adults by identifying children and adolescents with risk factors known to be associated with the development of CHD such as physical inactivity.<sup>14-16</sup> However, the present pilot survey indicates that very few pediatricians are actually doing any objective assessment of physical fitness in their office or providing children and adolescents and their families with exercise guidelines.

An investigation by Dennison and associates indicated that physical fitness testing in boys aided in the



**Figure 4:** Percentage of pediatricians identifying various barriers to determining fitness..


identification of individuals at increased risk of becoming physically inactive young adults.<sup>10</sup> Nader and associates,<sup>17</sup> in a national survey of pediatricians, reported that approximately 75% regularly discussed exercise during routine well-child visits in children six years of age and older. In addition they found that only 25% of those responding believed that pediatricians would be likely to be effective in promoting lifestyle changes related to exercise patterns of children and adolescents. Unfortunately Nader did not report what respondents meant when they stated they discussed exercise with their patients. The results from this study do not support Nader's findings that a majority of pediatricians routinely inquire about the physical activity patterns and physical fitness levels of their patients. This study found that only 19% of respondents obtained a detailed history of physical activity and only 7% completed any type of objective physical fitness testing as part of HSE. Additionally it was noted that most pediatricians depended on observations of their patients at rest instead of completing dynamic tests to assess physical fitness (Figure 2).

A very disappointing discovery from this study was that even in those instances where fitness data was objectively collected, very little was done with this information. Most of the pediatricians appear to limit their use of any data to recording it in the medical record for future reference or instructing patients and their families to increase their physical activities without providing them with the means of assessing whether or not they are improving or providing them with specific guidelines. This may be a result of the lack of training most pediatricians receive during their medical education relevant to exercise physiolo-



# Your Rx for Valium

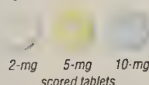
(brand of diazepam/Roche)



may be open to  
seventeen  
interpretations...

unless you settle the issue by signing  
on the "Dispense as Written" line.

**VALIUM**<sup>®</sup>  
brand of  
diazepam/Roche 



*The final choice should really be yours*

The cut out "V" design is a registered trademark of Roche Products Inc.  
Copyright © 1991 by Roche Products Inc. All rights reserved.

**ROCHE**

**Roche Products**

Roche Products Inc.  
Manati, Puerto Rico 00701

\*According to the Orange Book, 10th ed, US Department of Health  
and Human Services, 1990, diazepam tablets may be available from as many  
as 17 companies. Tablets shown represent 5 mg diazepam tablets.



gy and the lack of awareness most of them appear to have about the existence of any exercise guidelines and recommendations.

Pediatricians cited a number of barriers they believed prevented them from dynamically testing the physical fitness levels of their patients in their offices. Most of these limitations were related to space, time, and training. Almost all the respondents were interested in additional training related to exercise and physical fitness and a large number would be interested in incorporating a physical fitness test into their routine examinations if some of the barriers could be overcome (personal communication).

### Conclusion

Physical inactivity has been demonstrated to be a major modifiable risk factor associated with the development of CHD in adults. Multiple researchers have reported that physically inactive children and adolescents are likely to become physically inactive adults. This study reports that pediatricians in one state are not routinely providing evaluations, guidelines and recommendations to children, adolescents, and their families regarding the benefits of a physically active lifestyle. Fortunately the barriers listed by pediatricians to increasing their assessments of physical activity and physical fitness appears to these authors to be correctable. It is hoped that organizations such as the American Academy of Pediatrics and the American College of Sports Medicine could develop programs to encourage pediatricians to become more actively involved in increasing the level of physical activity and physical fitness of children and adolescents in the United States.

### Bibliography

1. NCHS. Vital statistics of the United States, 1987 Vol 2, part A. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, CDC, 1990; DHHS publication no. (PHS) 901701.
2. Castelli WP. Epidemiology of coronary heart disease: The Framingham study. *Am J of Med* 1984; 76:4-12.
3. Newman WP, Freedman DS, Voors AW, Gard PD et al. Relation of serum lipoprotein levels and systolic blood pressure to early atherosclerosis: The Bogalusa Heart Study. *NEJM* 1986; 314:138-44.
4. Webber LS, Cresanta JL, Voors AW, Berenson GS. Tracking of cardiovascular disease risk factor variables in school-age children. *J Chron Dis* 1983; 36:647-660.
5. Lauer RM, Lee J, Clarke WR. Factors affecting the relationship between childhood and adult cholesterol levels: The Muscatine Study. *Peds* 1988; 82:309-318.
6. Lauer RM, Clarke WR. Childhood risk factors for high adult blood pressure: The Muscatine Study. *Peds* 1988; 84:633-641.
7. Paffenbarger RS Jr., Hyde RT, Wing AL, Hsieh CC. Physical activity, all - cause mortality, and longevity of college alumni. *NEJM* 1986; 314:605-613.
8. Powell KE, Thompson PD, Caspersen CJ, Rendrick JS. Physical activity and the incidence of coronary heart disease. *Ann Rev. Public Health* 1987; 8: 253-287.

9. Centers for Disease Control. Protective effect of physical activity on coronary heart disease. *MMWR* 1987; 36:426-430.

10. Dennison BA, Straus JH, Mellits ED, Chamey E. Childhood physical fitness tests: Predictor of adult physical activity levels. *Ped* 1988; 82:324-330.

11. Ross JG, Delpy LA, Christenson GM, Gold RS, Danberg CL. The National Children and Youth Fitness Study II. *JOPERD* 1987; 58:5096.

12. Schwartz CJ, Ardlie NG, Carter RF, Paterson JC. Gross Aortic Sudanophilia and Hemosiderin Deposition: A study on infants, children and young adults. *Arch Path* 1967; 83:325-332.

13. Tanaka K, Masada J, Imamura T, Sueishik et al. A nation-wide study of atherosclerosis in infants, children and young adults in Japan. *Atherosclerosis* 1988; 72:143-156.

14. Sytkowski PA, Rannel WB, D'Agostino RB. Change in risk factors and the decline in mortality from cardiovascular disease: The Framingham Heart Study. *NEJM* 1990; 322:1635-41.

15. Manninen V, Elo MO, Frick MH, Haapak et al. Lipid alterations and decline in the incidence of coronary heart disease in the Helsinki Heart Study. *JAMA* 1988; 260:641-651.

16. Ornish D, Brown SE, Scherwitz LW, Billings JH et al. Can lifestyle changes reverse coronary heart disease: The Lifestyle Heart Trial. *Lancet* 1990; 336:129-133.

17. Nader PR, Taras HL, Sallis JF, Patterson TL. Adult heart disease prevention in childhood: A national survey of pediatricians' practices and attitudes. *Ped* 1987; 79:843-850.

---

## ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

---

BIRMINGHAM—Solo Cardiologist wants an Invasive or Non-Invasive Cardiologist to share the practice or the calls in the Birmingham, Alabama area. Send CV to : Alabama Medicine, Box A, P.O. Box 1900, Montgomery, AL 36102-1900.

---

FPS and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

---

ER PHYSICIANS NEEDED for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

# “...We made it!”

Tommy Powell, Class President  
Honors Convocation 1991  
UAB School of Medicine

## Editor's Note

*When Tommy Powell, President of his UAB Medical School Class of '91, spoke the following words, he was not yet an M.D. That came shortly after.*

*His excitement, his dedication, his faith in the profession he is entering, his commitment to healing, his gratitude for the great opportunity, and his appreciation for all those teachers, friends and family who assisted him—all these authentic emotions utterly contradict the doomsday pronouncements of some older physicians, those who swear they would steer their own children away from the profession. Medicine has gone to rack and ruin, to hear them tell it.*

*Reading this short address, such naysayers must be chagrined to learn that all their negative counsel seems to have bounced off the heads of the Class of '91. Youth is like that, always has been and always will be. It has the happy faculty for filtering the wisdom of tribal elders, separating the wheat from the chaff, the gold from the dross.*

*Since time immemorial, physicians have themselves supplied the gene pool for the perpetuation of the art and science, counseling their own children to follow in their footsteps. If this hereditary resource is weakened or destroyed, comments Mr./Dr. Powell's new father-in-law, former MASA President Ronald E. Henderson, M.D.(who proudly passed along this text to Alabama Medicine), humanity will have suffered a terrible loss along with the profession.*

*But the cries of desolation and damnation are patently false, Dr. Henderson believes: Physicians will continue to enjoy the material rewards, social standing, and enormous self-esteem that are virtually without parallel in our society.*

*Here, then, is the voice of a young doctor on the threshold of his career in the year 1991. His timeless*

*words could have been spoken 20, 50, or 100 years ago. Perhaps it will bring back some memories of that joyous occasion in your life, and with it the reassuring realization that the more medicine changes the more it is the same. Mr./Dr. Powell .....*

No greater opportunity, responsibility or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering he needs technical skill, scientific knowledge and human understanding. He who uses these with courage, with humility and with wisdom, will provide a unique service for his fellow man and will build an enduring edifice of character within himself. The physician asks of his destiny no more than this; he should be content with no less.”

As we come to the conclusion of medical school, we will be asked to accept the responsibilities and the lot of becoming a physician. Dr. Tinsley Harrison expressed that so well in the quote I just read.

In our next 10-15 years in medicine, we will finish our formal training programs, set up our practices and we will face challenges. Some of these challenges will be the same ones that our predecessors struggled with, but others will be new, having never before been faced. We have certainly faced challenges throughout medical school, from the first day when Dr. Hamel reminded us that it wasn't too late to go back to the beach; through pathology when many of us wished we had taken Dr. Hamel up on his offer; through Part I Boards and the stresses of that exam; to our clinical years and the opportunities and challenges that they provided; and finally to our senior year when we were somewhere between a student and an intern, knowing just enough to get us into trouble and not enough to get us out.

We've had good times, made new and lasting friendships, and seen thousands of slides. We've lost a lot of sleep, and some of us a lot of hair. Through it



all we have grown together as a class, and individually, and we have matured into young physicians. God has given each of us the ability and the University of Alabama School of Medicine has provided us with the foundation upon which we can go forth into the medical profession.

We have learned, not only to be *subjective* problem-solvers, but *objective* problem-solvers as well. We've learned to look at an opportunity whether it be a test, a patient's diagnosis or something personal, and approach it with a better degree of wisdom and skill, so that we might reach the most appropriate conclusion we can, in the most efficient manner possible.

I think we all would agree that medical school has not been easy, but as we finished college we thought it hadn't been easy either. Now, looking back, we realize how much easier it was than medical school, and I suspect that our residency programs are going to challenge us to an even greater degree. One day we'll probably reflect on medical school and wonder if it was as tough as we thought, and the answer will probably be, yes!

We all need to be grateful for the opportunities we've been given. There are many, many people in the world who would give great treasures to have had the opportunities that we have enjoyed, and those which we are about to face. Let us remember also, that of those to whom much is given much is expected. I hope that we'll never take our medical education for granted, and that it will not stop here today! Oliver Wendell Holmes once said: "the mind once expanded never returns to the original size."

Our minds have definitely been expanded, our brains challenged, and we have learned so much, so fast. We need to continue to cultivate our intellect throughout our lives.

In continuing along that same line of thought, Dr. Tinsley Harrison said: "Teachers usually err in thinking that learning is entirely a matter of the mind. Nothing could be farther from the truth. Only by stimulating the student to self-education and inner motiva-

tion, which comes through enthusiasm.... only this way can the teacher really accomplish learning in the student."

Thank you, teachers, who have inspired us to do just that, to want to learn. May we leave this school with an insatiable desire to be the best physicians, scholars, citizens, spouses and parents that we can possibly be. And remember what Daniel Webster said: "there is always room at the top."

Thank you for the guidance that the Office of Medical Student services has given us, and thank you, family and friends, who have been there when we needed you. You have been supportive and understanding, even when we were less than desirable to be around.

Now as we depart from medical school, I would like to read a quote from the book, Illusions, by Richard Bach:

"Don't turn away from possible futures before you're certain you don't have anything to learn from them. You're always free to change your mind and choose a different future.... There is no such thing as a problem without a gift for you in its hand. Remember where you came from, where you're going and why you created the mess you got yourself into in the first place."

As we look now to the end of this convocation, toward being graduated Doctors of Medicine and to beginning our residency programs, let's not forget to enjoy what comes along the way.

Sir Archibald Garrod said when asked what makes a good doctor: "He needs to be equipped with tact, resourcefulness, courage and prudence. He have patience with fads, consideration for his patients and their friends, sympathy with suffering, and gentleness of touch and voice. Much indeed is asked of him, but without these qualities, be he ever so able, he will make a poor practitioner."

May we always strive for the best, never be discouraged by the worst and keep moving.

Remember saying you were going to be a doctor? Well, we made it!

# EIGHT GOOD REASONS TO SWITCH HEALTH INSURANCE COMPANIES

---

## 1 LOW RATES

*Compare our premiums to what you're paying now*

## 2 CHOICE OF DEDUCTIBLES WITHIN YOUR GROUP

*Mixing deductibles within your group can help control expenses*

## 3 PERSONAL SERVICE

*We're large enough to meet your needs - yet small enough to care*

## 4 A TRADITION OF TRUST

*We've been serving health care professionals exclusively since 1978*

## 5 AN A+ FOR FINANCIAL STRENGTH AND STABILITY

*Affiliated with Mutual Assurance, rated A+ by A.M. Best*

## 6 A CHOICE OF PROVIDERS

*Total freedom to choose the doctors you want to use*

## 7 RAPID CLAIMS HANDLING

*Most claims paid within two weeks*

## 8 NO PRE-CERTIFICATION REQUIRED

*No administrative headaches or hassles for you or your family*

IF YOU THINK THESE ARE GOOD REASONS  
CALL 1-800 344-9588

**LifeSouth**

PROFESSIONAL'S HEALTH PLAN



# Alabama Medicine Index—Volume 60

July 1990—June 1991

## AUTHORS

### A.

Adams, Paul W., M.D., et al., "Permanent Transperineal Iodine," Vol. 60, No. 5, p. 18.

American Medical Association, "Long-Term Care Financing Update," Vol. 60, No. 8, p. 24.

American Society of Internal Medicine, "OBRA '90 and the Hassle Factor," Vol. 60, No. 8, p. 8.

AMA Investment Advisers, Inc., "The High Cost of Higher Education," Vol. 60, No. 12, p. 12.

Austin, Mitchell A., M.D., et al., "Functional Endoscopic Sinus Surgery," Vol. 60, No. 7, p. 24.

### B.

Bean, Mrs. Stuart K., "A Partnership Project," Vol. 60, No. 11, p. 26.

Blanton, James H., M.D., "Hospice—Let It Work For You," Vol. 60, No. 12, p. 2.

Borgeson, Virginia A., et al., "Are Your Patients Managing Your Finances?" Vol. 60, No. 10, p. 24; "Decisions That Pay Off," Vol. 60, No. 4, p. 30.

Boudreaux, Arthur M., M.D., et al., "Toward Less Painful Local Anesthesia," Vol. 60, No. 4, p. 18.

Brody, Baruch A., PhD, "Physicians and Rationing," Vol. 60, No. 8, p. 16.

Brouillette, J. N., M.D., "The Coke Factor," Vol. 60, No. 12, p. 31.

Brown, Claude L., M.D., "The Return of Agamemnon," Vol. 60, No. 3, p. 14; "Can Pleasure Be Quantified In Dollars?" Vol. 60, No. 10, p. 16.

### C.

Conner, S. Lon, "C'est la guerre," Vol. 60, No. 6, p. 2; "A Closer Look," Vol. 60, No. 1, p. 4; "Darkness at Noon," Vol. 60, No. 4, p. 4; "Lighten Up Doctor," Vol. 60, No. 11, p. 2; "More Smoke, More Mirrors," Vol. 60, No. 5, p. 4; "Of Time and the River," Vol. 60, No. 8, p. 2; "Pricing Under Socialism," Vol. 60, No. 6, p. 2; "The Richness of Diversity," Vol. 60, No. 9, p. 2; "The Rule of Rescue," Vol. 60, No. 10, p. 2; "Short-Lived Peace Dividend," Vol. 60, No. 3, p. 4; "600,000 X 1," Vol. 60, No. 12, p. 4.

Crump, William J., M.D., et al., "Impact of Family Physicians' Cessation of Obstetric Care," Vol. 60, No. 3, p. 24; "OBRA '90 and the Hassle Factor," Vol. 60, No. 8, p. 8.

### D.

Davis, Stephen A., M.D., "Don't Write Off RBRVS," Vol. 60, No. 11, p. 26.

Duchene, James C., Esq., "Physician and Provider Obligations Under the Medicare Antidumping Provisions," Vol. 60, No. 1, p. 28.

### E.

Eichold, Bernard H., II, M.D., et al., "HMO—A Hard

Product To Sell," Vol. 60, No. 12, p. 30.

Esham, Richard H., M.D., "Orwell + 6 Years," Vol. 60, No. 3, p. 11.

## F.

Fox, Mark D., "The Abiding Validity of the Hippocratic Oath," Vol. 60, No. 7, p. 6.

Francis, Kennon, Ph.D., et al., "Heat Illness in Football Players in Alabama," Vol. 60., No. 9, p. 10.

## G.

Garner, Margaret Pipkin, M.S., R.D., L.D., "Nutrition Counseling: Guidelines for the Practicing Physicians," Vol. 60, No. 1, p. 34.

## H.

Hall, W. Michael, M.D., et al., "Intensive Care Experience With Intravenous Cimetidine," Vol. 60, No. 4, p. 22.

Hand, Stanley D., M.D., "The Fable of the Federally Financed Furniture Factories," Vol. 60, No. 9, p. 17.

Harris, LeRoy F., M.D., et al., "Mucormycosis: A Community Hospital Perspective," Vol. 60, No. 1, p. 38; "Staphylococcus Aureus Endocarditis," Vol. 60, No. 11, p. 9.

Harve, Dale C., M.D., "Kinder, Gentler Procedure," Vol. 60, No. 7, p. 18.

Herrick, Richard T., M.D., et al., "Tarsal Tunnel Syndrome," Vol. 60, No. 1, p. 40.

Hicks, Julius N., M.D., et al., "Functional Endoscopic Sinus Surgery," Vol. 60, No. 7, p. 24.

Hon, Jeremy K., M.D., et al., "Mucormycosis: A Community Hospital Perspective," Vol. 60, No. 1, p. 38.

## K.

Kan, William, M.S., et al., "Permanent Transperineal Iodine," Vol. 60, No. 5, p. 18.

Kavaler, Florence, M.D., M.P.H., "Responsibilities of Health Yuppies," Vol. 60, No. 8, p. 22.

Kent, Raleigh B., III, M.D., et al., "Toward Less Painful Local Anesthesia," Vol. 60, No. 4, p. 18.

Kim, Robert Y., M.D., "Extradural Spinal Cord Compression From Metastatic Tumor," Vol. 60, No. 1, p. 10.

Kotlarz, Jack P., M.D., et al., "Functional Endoscopic Sinus Surgery," Vol. 60, No. 7, p. 24.

## L.

LaCour, Fritz A., Jr., M.D., "Huntingtons Disease," Vol. 60, No. 1, p. 16.

Laney, James T., PhD., "Ethics in Health Care: What Do We Have To Do? What Should We Do?" Vol. 60, No. 6, p. 12.

Laughlin, Edward H., M.D., "Treatment of Early-Stage Breast Cancer," Vol. 60, No. 10, p. 10.

Lazenby, William D., M.D., "Commitment," Vol. 60, No. 12, p. 8; "Is Organized Medicine Dying?" Vol. 60, No. 11, p. 6.

Lumpkin, T. Riley, M.D., "The Art of Medicine," Vol. 60, No. 1, p. 6; "Board of Censors," Vol. 60, No. 5, p. 8; "Potpourri or Guidelines for Life," Vol. 60, No. 6, p. 8; "Nutrition Counseling: Guidelines for the Practicing Physicians," Vol. 60, No. 1, p. 34; "So Long, Good-bye, Thanks a Million," Vol. 60, No. 10, p. 8; "Ties That Bind," Vol. 60, No. 9, p. 4; "Success!" (part 1), Vol. 60, No. 7, p. 4; "Success!" (part 2), Vol. 60, No. 8, p. 6; "The Wheel of Medicine," Vol. 60, No. 3, p. 6; "Your Hidden Assets," Vol. 60, No. 4, p. 8.

Loftin, Lee H., M.D., "Current Treatment of Otitis Media," Vol. 60, No. 12, p. 24.

## M.

McClain, David A., M.D., F.A.C.P., F.A.C.R., "Highlights of the Eighth Annual Rheumatology on the Beach," Vol. 60, No. 11, p. 18.

McCoy, Walter C., M.D., "No Hospital for Me," Vol. 60, No. 6, p. 21.

McDermott, Kathleen E., "Targeting Professions for Antitrust Prosecution: Perception or Reality?" Vol. 60, No. 7, p. 20.

McDonald, William H., "Return of the Native," Vol. 60, No. 9, p. 6.





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association

## N.

Nagendran, S., M.D., and Nagendran, T., M.D., "Mechanisms and Treatment of Nausea and Vomiting," Vol. 60, No. 5, p. 12.

Nelson, Leonard J., LL.D., et al., "Medical Malpractice and Access to Obstetrical Care in Alabama," Vol. 60, No. 12, p. 14.

## P.

Patterson, Mrs. Charles , "Alabama's Front Row Seat," Vol. 60, No. 3, p. 32; "aux•il•ia•ry," Vol. 60, No. 1, p. 50; "Doctors' Day Goes National," Vol. 60, No. 9, p. 28; "The Gift That Keeps On Giving," Vol. 60, No. 4, p. 32; "Make A Difference," Vol. 60, No. 5, p. 24; "Mobile Auxiliary Adopts A School," Vol. 60, No. 8, p. 30; "A New Season," Vol. 60, No. 10, p. 30; "Our Auxiliary Stars," Vol. 60, No. 6, p. 18; "The Rest of the Star Story," Vol. 60, No. 7, p. 30.

Pittman, James A., Jr., M.D., "That We Might Learn..." Vol. 60, No. 7, p. 27.

## R.

Redd, David A., M.D., et al., "Toward Less Painful Local Anesthesia," Vol. 60, No. 4, p. 18.

Real, Jack D., M.D., et al., "Permanent Transperineal Iodine," Vol. 60, No. 5, p. 18.

Robbins, William C., M.D., et al., "Acute Renal Failure Secondary to Fecal Impaction," Vol. 60, No. 9, p. 20.

## S.

Schreeder, Marshall T., M.D., et al., "Mucormycosis: A Community Hospital Perspective," Vol. 60, No. 1, p. 38.

Sheehy, Thomas W., M.D., "Scurvy," Vol. 60, No. 4, p. 11.

Silvernail, William I., Jr., M.D., "Hazards of Aging," Vol. 60, No. 4, p. 20; "Patient's Rights," Vol. 60, No. 7, p. 12.

Sneed, Rodney, M.D., "The Alabama Automated Defibrillation Pilot Program," Vol. 60, No. 1, p. 26.

Soled, Morris, M.D., "Aphorisms of Hippocrates," Vol. 60, No. 7, p. 10.

Stokes, Steven H., M.D., et al., "Permanent Transperineal Iodine," Vol. 60, No. 5, p. 18.

## T.

Taylor, Fonde, "Using a Systems Approach to Medical Office Management," Vol. 60, No. 9, p. 22.

## Z.

Zagel, James B., Judge, et al., "Can Pleasure Be Quantified In Dollars?" Vol. 60, No. 10, p. 16.

# TITLES

## A.

"The Abiding Validity of the Hippocratic Oath," Fox, Mark D., Vol. 60, No. 7, p. 6.

"Acute Renal Failure Secondary to Fecal Impaction," Robbins, William C., M.D., et al., Vol. 60, No. 9, p. 20.

"The Alabama Automated Defibrillation Pilot Program," Sneed, Rodney, M.D., Vol. 60, No. 1, p. 26.

"Alabama's Font Row Seat," Patterson, Mrs. Charles, Vol. 60, No. 3, p. 32.

"Aphorisms of Hippocrates," Soled, Morris, M.D., Vol. 60, No. 7, p. 10.

"Are Your Patients Managing Your Finances?" Borgeson, Virginia A., et al., Vol. 60, No. 10, p. 24.

"The Art of Medicine," Lumpkin, T. Riley, M.D., Vol. 60, No. 1, p. 6.

"aux•il•ia•ry," Patterson, Mrs. Charles, Vol. 60, No. 1, p. 50.

## B.

"Board of Censors," Lumpkin, T. Riley, M.D., Vol. 60, No. 5, p. 8;

## C.

"Can Pleasure Be Quantified in Dollars?" Brown, Claude L., M.D., Vol. 60, No. 10, p.16.



"C'est la guerre," Conner, S. Lon, Vol. 60, No. 6, p. 2.

"A Closer Look," Conner, S. Lon, Vol. 60, No. 1, p.4.

"The Coke Factor," Brouillette, J. N., M.D., Vol. 60, No. 12, p. 31.

"Commitment," Lazenby, William D., M.D., Vol. 60, No. 12, p. 8.

"Current Treatment of Otitis Media," Loftin, Lee H., M.D., Vol. 60, No. 12, p. 24.

#### D.

"Darkness at Noon," Conner, S. Lon, Vol. 60, No. 4, p. 4.

"Decisions That Pay Off," Borgeson, Virginia A., et al., Vol. 60, No. 4, p. 30.

"Doctors' Day Goes National," Patterson, Mrs. Charles, Vol. 60, No. 9, p.28.

"Don't Write Off RBRVS," Davis, Stephen A., M.D., Vol. 60, No. 11, p. 26.

#### E.

"Ethics in Health Care: What Do We Have To Do? What Should We Do?" Laney, James T., PhD., Vol. 60, No. 6, p. 12.

"Extradural Spinal Cord Compression From Metastatic Tumor," Kim, Robert Y., M.D., Vol. 60, No. 1, p. 10.

#### F.

"The Fable of the Federally Financed Furniture Factories," Hand, Stanley D., M.D., Vol. 60, No. 9, p. 17.

"Functional Endoscopic Sinus Surgery," Hicks, Julius N., M.D., et al., Vol. 60, No. 7, p. 24.

#### G.

"The Gift That Keeps On Giving," Patterson, Mrs. Charles, Vol. 60, No. 4, p. 32.

#### H.

"Hazards of Aging," Silvernail, William I., Jr., M.D., Vol. 60, No. 4, p. 20.

"Heat Illness in Football Players in Alabama,"

Francis, Kennon, Ph.D., et al., Vol. 60., No. 9, p. 10.

"The High Cost of Higher Education," AMA Investment Advisers, Inc., Vol. 60, No. 12, p. 12.

"Highlights of the Eighth Annual Rheumatology on the Beach," McClain, David A., M.D., F.A.C.P., F.A.C.R., Vol. 60, No. 11, p. 18.

"HMO—A Hard Product To Sell," Eichold, Bernard H., II, M.D., et al., Vol. 60, No. 12, p. 30.

"Hospice—Let It Work For You," Blanton, James H., M.D., Vol. 60, No. 12, p. 2.

"Huntingtons Disease," LaCour, Fritz A., Jr., M.D., Vol. 60, No. 1, p. 16.

#### I.

"Impact of Family Physicians' Cessation of Obstetric Care," Crump, William J., M.D., et al., Vol. 60, No. 3, p. 24.

"Intensive Care Experience With Intravenous Cimetidine," Hall, W. Michael, M.D., et al., Vol. 60, No. 4, p. 22.

"Is Organized Medicine Dying?" Lazenby, William D., M.D., Vol. 60, No. 11, p. 6.

#### K.

"Kinder, Gentler Procedure," Harve, Dale C., M.D., Vol. 60, No. 7, p. 18.

#### L.

"Lighten Up Doctor," Conner, S. Lon, Vol. 60, No. 11, p. 2.

"Long-Term Care Financing Update," American Medical Association, Vol. 60, No. 8, p. 24.

#### M.

"Make A Difference," Patterson, Mrs. Charles, Vol. 60, No. 5, p. 24.

"Mechanisms and Treatment of Nausea and Vomiting," Nagendran, S., M.D., and Nagendran, T., M.D., Vol. 60, No. 5, p. 12.

"Medical Malpractice and Access to Obstetrical Care in Alabama," Nelson, Leonard J., LL.D., et al., Vol. 60, No. 12, p. 14.

# AIM HIGH

## **SPECIALIZE IN AIR FORCE MEDICINE.**

ER Physicians. Radiologists. OB/GYNs and other specialists!

Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

**USAF HEALTH  
PROFESSIONS  
1-800-423-USAF  
TOLL FREE**





"More Smoke, More Mirrors," Conner, S. Lon, Vol. 60, No. 5, p.4.

"Mobile Auxiliary Adopts A School," Patterson, Mrs. Charles, Vol. 60, No. 8, p. 30.

"Mucormycosis: A Community Hospital Perspective," Harris, LeRoy F., M.D., Vol. 60, No. 1, p. 38.

#### N.

"A New Season," Patterson, Mrs. Charles, Vol. 60, No. 10, p. 30.

"No Hospital for Me," McCoy, Walter C., M.D., Vol. 60, No. 6, p. 21.

"Nutrition Counseling: Guidelines for the Practicing Physicians," Lumpkin, T. Riley, M.D., et al., Vol. 60, No. 1, p. 34.

#### O.

"OBRA '90 and the Hassle Factor," American Society of Internal Medicine, Vol. 60, No. 8, p. 8.

"Of Time and the River," Conner, S. Lon, Vol. 60, No. 8, p. 2.

"Orwell + 6 Years," Esham, Richard H., M.D., Vol. 60, No. 3, p. 11.

"Our Auxiliary Stars," Patterson, Mrs. Charles, Vol. 60, No. 6, p. 18.

#### P.

"A Partnership Project," Bean, Mrs. Stuart K., Vol. 60, No. 11, p. 26.

"Patient's Rights," Silvermail, William I., Jr., M.D., Vol. 60, No. 7, p. 12.

"Permanent Transperineal Iodine," Stokes, Steven H., M.D., et al., Vol. 60, No. 5, p. 18.

"Physician and Provider Obligations Under the Medicare Antidumping Provisions," Duchene, James C., Esq., Vol. 60, No. 1, p. 28.

"Physicians and Rationing," Brody, Baruch A., PhD, Vol. 60, No. 8, p.16.

"Potpourri or Guidelines for Life," Lumpkin, T. Riley, M.D., Vol. 60, No. 6, p. 8.

"Pricing Under Socialism," Conner, S. Lon, Vol. 60, No. 6, p. 2.

#### R.

"The Rest of the Star Story," Patterson, Mrs. Charles, Vol. 60, No. 7, p. 30.

"Return of the Native," McDonald, William H., Vol. 60, No. 9, p. 6.

"The Richness of Diversity," Conner, S. Lon, Vol. 60, No. 9, p. 2.

"Responsibilities of Health Yuppies," Kavalier, Florence, M.D., M.P.H., Vol. 60, No. 8, p. 22.

"The Return of Agamemnon," Brown, Claude L., M.D., Vol. 60, No. 3, p. 14.

"The Rule of Rescue," Conner, S. Lon, Vol. 60, No. 10, p. 2.

#### S.

"600,000 X 1," Conner, S. Lon, Vol. 60, No. 12, p. 4.

"Scurvy," Sheehy, Thomas W., M.D., Vol. 60, No. 4, p. 11.

"Short-Lived Peace Dividend," Conner, S. Lon, Vol. 60, No. 3, p. 4.

"So Long, Good-bye, Thanks a Million," Lumpkin, T. Riley, M.D., Vol. 60, No. 10, p. 8.

"Staphylococcus Aureus Endocarditis," Harris, LeRoy F., M.D., Vol. 60, No. 11, p. 9.

"Success!" Lumpkin, T. Riley, M.D., (part 1), Vol. 60, No. 7, p. 4; "Success!" (part 2), Vol. 60, No. 8, p. 6.

#### T.

"Targeting Professions for Antitrust Prosecution: Perception or Reality?" McDermott, Kathleen E., Vol. 60, No. 7, p. 20.

"Tarsal Tunnel Syndrome," Herrick, Richard T., M.D., et al., Vol. 60, No. 1, p. 40.

"That We Might Learn..." Pittman, James A., Jr.,

M.D., Vol. 60, No. 7, p. 27.

"Ties That Bind," Lumpkin, T. Riley, M.D., Vol. 60, No. 9, p. 4.

"Toward Less Painful Local Anesthesia," Redd, David A., M.D., et al., Vol. 60, No. 4, p. 18.

"Treatment of Early-Stage Breast Cancer," Laughlin, Edward H., M.D., Vol. 60, No. 10, p. 10.

U.

"Using a Systems Approach to Medical Office Management," Taylor, Fonde, Vol. 60, No. 9, p. 22.

W.

"The Wheel of Medicine," Lumpkin, T. Riley, M.D., Vol. 60, No. 3, p. 6.

Y.

"Your Hidden Assets," Lumpkin, T. Riley, M.D., Vol. 60, No. 4, p. 8.

---

## The Investment Food Chain

*James W. Mangham, III\**

Inefficiencies in investment services coupled with charges not appropriate to results are the norm rather than the exception in the investment field.

Rarely do investment professionals take all costs of investments into account when quoting the rates of return achieved for their clients. Equally rarely do clients realize how the returns are calculated. Frustrating though it may be, you must figure out for yourself all costs involved with an investment so that you can determine the rate of return involved.

What costs should be considered? As an example, let's outline costs which may be associated with a physician's retirement plan as the monies therein usually are a large portion of a doctor's assets: trustee's fees and other charges, investment manager's fees, broker's commissions and other charges, plan administrator charges, plan document costs, attorney's fees, insurance commissions and other charges, accountant's fees, other such costs.

Without putting a pencil to it, one may wonder how any retirement plan generates a positive rate of return after "costs" are taken into account. Precisely

the point. And if your rate of return, without consideration of such costs is feeble to start with, or is inaccurately presented to you even in its gross amount, *you are at the wrong end of the food chain.*

What can be done to bring your costs in line? Negotiate! Every expense involved can be brought to an acceptable level. Then insist that all such costs be fully disclosed and taken into account every time a rate of return is quoted to you before and after all costs.

What is an acceptable level for combined costs? It depends. For example, costs associated with retirement plans in which assets exceed \$100,000 in value should not exceed an annual amount of more than 2% of the value of the assets in the plan.

What is an acceptable gross rate of return? You should expect a minimum of 10% per annum before costs. Further, you should expect consistency in cranking out such returns, quarter after quarter. How long should it take to evaluate performance? Not long. A sound game plan should achieve readily apparent results within two quarters. Your financial life depends on your making sound decisions about whom you trust with your money.

---

*\*President, Investment Advisory & Management Corporation, Mobile, Alabama.*



# Working Together: PA/MD Bonding A Duet, Not A Duel

*Robert L. Bloomfield, M.D., F.A.C.P.\**

*Reprinted From North Carolina Medical Journal*

You've heard it before: how doctors make poor patients and how an illness can be a valuable experience for a physician. What caught me by surprise was the realization that the concept of a physician assistant was more than just a concept when an associate was disabled.

I was the medical director of the Physician Assistant Program at the Bowman Gray School of Medicine when I was afflicted by a stroke. Though some of my colleagues might disagree, I felt I was in the prime of my career. Two years earlier I had reported my own case history in a prominent ophthalmology journal as an unusual phakomatosis with skin, retinal and central nervous system hemangiomas.

I recall warning my freshman students to avoid certain attending physicians' patients for interviews, because these particular doctors were unfriendly to physician assistant students. When I mentioned one name, a student interrupted me and said, "Oh, he died this weekend." I felt awful and realized how fragile we really are. A week later I was lying in a hospital bed.

I also recall telling incoming students that they didn't have to look far for pathology. There were more than enough abnormalities for studying physical diagnosis among the student body and faculty. Now six months later I was a walking (barely) textbook of neurology.

Sure life is filled with ironies. But I had a lot of advantages: patient and understanding parents—"Sure, Bob, do whatever you like, Radiology, Ophthalmology or Plastic Surgery;" and supportive patients—"You warn me about salt and not taking my medicine; then you go and have a stroke."

But the greatest blessing of all was realizing that I

had potential planted outside myself, in the clinicians I had bonded with during my teaching years. I had lost my voice, my balance and my coordination, but I still had part of my brainstem, a heart and some courage. One physician assistant made it possible to enjoy Medicine again.

Working alongside a graduate from the PA Program had always been a duet, not a duel. Now we had to modify the bond. There was no more time for Abbott and Costello routines. There was a deadline to meet so that we had to work more like Watson and Crick. The DNA model was a good one to approximate. Biology had taught me: good things come in pairs.

I noted that the weaker I was, the stronger my associate was. That seemed to be the beauty of dyadic interaction. One may really transfer power and knowledge to another and this transfer is catalyzed by an inherent difference or polarity of the two objects. There's a law of physics in there somewhere.

The PA became my eyes, ears and hands. Meanwhile, I became a more acute observer; certainly a more empathetic observer. And in being so, I learned a lot about my partner's techniques.

Another thing I noted was that once we solved our own problems, the difficulties the patients had were much easier to tackle. And the patients would open up to an ill-appearing practitioner easily. There is so much leverage afforded by an unfortunate situation. Though the genetic material may be flawed, the double helix through the flexibility of the bonds succeeds.

In a new or changed dyad, you're willing to perform new and daring feats. It's necessary to survive as a duo. Stable environments produce stereotyped patterns of interactions with patients and colleagues. The variable setting provided by collaboration allows more flexibility. Ideally, one clinician enters into

---

From the Department of Medicine, Bowman Gray School of Medicine, Winston-Salem, 271 03.

action when the limits of his co-worker are exceeded, serving a shock-absorbing function.

A collaborator prods us to look at ourselves and our work in new ways. In science, genius is no assurance against a narrowed perspective. In *The Double Helix*, James Watson describes how he and Francis Crick discovered the molecular structure of DNA. He recounts how Linus Pauling made an error that contradicted his own proven biochemical theories about chemical bonds. When Pauling's paper about the triple alpha helix model was published, his error was obvious to Watson and Crick.

We all know that three's a crowd. Working alone, Pauling lacked a valuable second opinion. Watson and Crick imitated Pauling and beat him at his own game.

Consider also the sponge and hydra that can regenerate themselves after being forced through a wire mesh. And the small pieces of a flatworm can regenerate into a whole organism. We, of course, can't

reproduce asexually; biosociation of two different genetic codes is the basic model for the successful creative act.

Observing patients from a greater distance is akin to ghostwriting. This offers a vicarious element as one relives the experiences of the co-worker. In doing so, one is forced to undergo a transfer of personality (from Dr. Jekyll to Mr. H-Y-D-E). Ghosting is a useful exercise of putting oneself in someone else's shoes.

Seeing patients together should be like two actors going on stage fusing their talents and time together. Thinking of such a relationship as an interface of two scripts suggests the possibility of rewriting and editing aspects of such a partnership.

Compatibility is not a prerequisite for a successful collaboration. Gilbert and Sullivan quarrelled incessantly during their 20-year partnership. Sometimes dissonance or even hostility can energize a team. Garbled communication can be turned to one's advan-

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

<u>MALE AGES</u>	<u>\$250,000</u>	<u>\$500,000</u>	<u>\$1,000,000</u>
25	248.00	455.00	845.00
30	248.00	455.00	845.00
35	255.00	460.00	875.00
40	298.00	545.00	1,045.00
45	348.00	645.00	1,245.00
50	430.00	810.00	1,575.00
55	600.00	1,150.00	2,255.00
60	875.00	1,700.00	3,355.00
65	1,525.00	3,000.00	5,955.00

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

**COOK & ASSOCIATES**

P.O. Box 850517 • Mobile, Alabama 36685-0517 • (205) 341-5168

Above rates are provided by Jackson National Life



tage by opening a humorous potential. Consider the following example:

A bicycle salesman expounds the virtues of a particular bicycle to a prospective buyer. "You climb on this beauty at eight o'clock and by midnight you'll be in Chapel Hill." The customer curtly replies, "That's a fine thing. I don't know a soul in Chapel Hill and I'm stranded there at midnight."

This shift of emphasis to a seemingly irrelevant aspect of a concept is frequently the basis for enlightenment in art and scientific discovery. When one partner displaces attention to some neglected characteristic of the physical exam, a new set of possibilities emerges.

Working together on any project at times will border on an invasion of Privacy. This can lead to intense rivalry or it may foster an increased capacity to put oneself in the skin of another, a key interviewing skill.

Co-workers live in a dynamic equilibrium. This

presents us with a challenge that requires a restructuring of our mental organization to live in a symbiotic relationship. At times, there is a dangerous sublimation of the ego. Although some are convinced that collaboration can't be taught, and that the chemistry either works or it doesn't, I don't agree.

The nature of the bond between the famous Siamese Twins from rural North Carolina, Chang and Eng, was controversial. Why was it that Eng, who was perfectly healthy, died one hour after Chang, who was critically ill? The consensus was that Eng's death had nothing to do with a vital biological connection. However, Chang and Eng believed that the bond between them was vital.

A productive team does not share such a deterministic outlook. Ideally, collaboration is an amalgamation of two realms; a cohesive unit that belies the effort that it took to fuse the two together. The model we're seeking is the genetic material, the stuff people are made of.

## Term Life for Less... Much Less

They said compare, so we did.

Review these low male, non-smoker annual rates and call for quotes.

<u>AGE</u>	<u>\$250,000</u>	<u>\$500,000</u>	<u>\$1,000,000</u>
25	175*	275	500
30	175*	275	500
35	190*	305	560
40	210	340	630
45	235	385	720
50	373	635	1,220
55	525	975	1,900
60	838	1,625	3,200

All coverage is provided by companies rated A by A.M. Best Co. (Female rates lower)

Call (205) 279-8756 for quotes

H. Ben Coker III, CLU, ChFC  
Specialist in Life, Health & Disability

2835 Zelda Rd #7 Montgomery, AL 36106

\*200 minimum premium required by First International Life Insurance company

# Practice Parameters Blues

*Ira Green, M.D.\*  
In Missouri Medicine*

American medicine is being driven toward considerably greater standardization than is the case today. While the forces responsible for this development are various, by far the most important are the economic realities of contemporary health care.

The federal government, assorted third party payors, big business, hospital managers and their trade associations, and yes, even the American Medical Association and most specialty societies—not to mention think-tank health care experts—have climbed aboard the practice parameters express.

There is an emerging consensus that the evaluation of health care must be linked closely to collective “wisdom” as distilled from analysis of presumably objective data derived from the aggregated experience of large numbers of patients. The cry heard throughout the land these days amounts to this: “Find out what works; mandate adherence to standards of care consistent with this knowledge.”

It will come as little surprise to regular readers of this column that I am not convinced that those who champion the standardization idol have found the true religion. Count me, at best, as “agnostic” in the clamor for the orthodoxy.

Human beings have a remarkable capacity for concluding that whatever they wish to be true either is true, or can be so. The practice parameters movement now underway in health care evaluation circles could demonstrate this phenomenon once again.

Don't get me wrong. I am a strong believer in the importance of medical research and the full dissemination of knowledge as it emerges. My concern is that too many of the advocates of linking medical practice to an analysis of outcomes have an inadequate appreciation of just how hard science can be. The danger is that after years of data accumulation, analysis, panel discussions and assorted agonizing—all undertaken at

great expense—there will be conferred upon whatever emerges the mantle of “scientifically established” practice parameters. Whether or not such an appellation is warranted may not matter. Those who want to believe that what emerge are, in fact, legitimate standards may insist on conformity with the “truth” thus established.

Suppose, however, that consensus building is not the surest way to know truth? What then? Ask Copernicus, or Galileo, or Einstein. The danger is that the weight of opinion mustered to enforce the orthodox view will have a chilling effect on innovation. In a worst case scenario, progress could be stultified. Medicine might be changed from an art tutored mightily by science into a malevolent pseudoscience.

Do I believe that the present fervor for standardization will proceed? It appears certain to do so. What physicians must do, however, is assure that statistics and rules do not supplant informed medical judgment. We must be active participants in the dialogue concerning practice parameters. It is our challenge to assure that what emerges is valid. There must be recognition that in some areas of knowledge we are not at a point where more than the most tentative parameters are appropriate.

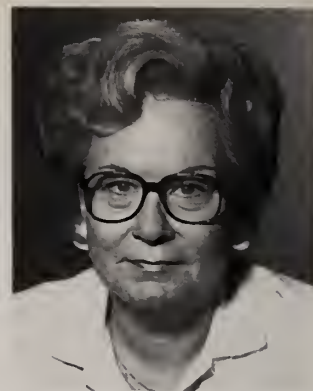
The course I propose for physicians is watchful participation in the dialogue regarding standardization. We must be vigilant in resisting inappropriate parameters. It would be foolish, however, to assume prematurely that no good will come of the endeavor. We must embrace what makes sense and shun what does not.

In some respects, the easiest course for physicians would be to practice within the dictates of whatever parameters emerge, even wrong minded ones. But we owe it to our profession and, more importantly, to our patients to do far better than that. Through active involvement in the guideline development process, we can improve the end result. Along the way, perhaps, we can alert policymakers to the danger of investing guidelines with the stature of holy writ!

---

\*Editor's Note: Ira Green, M.D., is President of the Medical Society of Virginia Review Organization. This President's Message is reprinted with permission from Volume 6, No. 6 (November 1990) of the MSVRO Reports.





*Mrs. Stuart K. Bean  
A-MASA, President*

## Schendal, M.D., In Iraq

When they moved to Cullman, Alabama, in December of 1989, Michael Schendal, M.D., and his wife Jacqueline expected to find life a little different from that they left in Louisiana. But when politics heated up in the Persian Gulf the Schendal family found life more interesting than they could ever have expected.

As a member of the 4010th Army Reserve Medical Hospital based in New Orleans, Louisiana, Dr. Schendal was called to active duty December 6, 1990, eleven months after coming to Alabama. Three months later as the Persian Gulf War began, he was flown to Saudi Arabia and separated from others in his unit to join the Third Armored Division on the front lines near Iraq. Once ground fighting began he moved with them into Iraq to within 30 miles of Basra.

Trying to keep things at home as normal as possible Mrs. Schendal remained in Cullman working in her husband's family practice office. "After getting over the initial shock, you just say, OK, what are we going to do and how are we going to handle this?" she says. The couple have two children ages eight and nine, and she chose to keep them in school and tried to continue life as usual. At the office Mrs. Schendal opened mail, answered the phone and tried to make sure that patients had a doctor to see them while her husband was away. Their employees moved on to other jobs. "We cut back on things and had to make do," Mrs. Schendal relates.

Meantime Dr. Schendal did not have a "cushy" job.

He rode across the desert in a bus to join the Third Armored Division. The first night in Saudi Arabia he slept in a tent. The second night he and others slept in the bus and the next night on top of the bus in sleeping bags, despite the wintry weather. They ate the infamous MREs (Meals Ready to Eat) and tried to keep the sand out.

Dr. Schendal was not able to call home for three weeks. Mrs. Schendal got no mail and was not able to send any to her husband during those weeks. This was about the time two doctors were killed in Iraq, and she had to assume that no news was good news.

Dr. Schendal stayed with the division for about a month in Iraq. He was assigned to a compound when first there and could not leave it. He walked the perimeter, played cards and ate. Mrs. Schendal says this was a difficult time for her husband when he was thinking, "When am I going to get to go home; what is my practice going to be like; and how are my wife and kids." Since casualties as a result of the war were light, Dr. Schendal eventually kept busy as one of six doctors in the division responsible for the daily health care of U.S. soldiers. He also cared for Iraqi POWs and local residents treating minor injuries and some gunshot wounds.

These doctors were housed in a tent with a dirt floor. There was no electricity or plumbing and no heat. Dr. Schendal slept in a sleeping bag the whole time he was in Iraq, was not able to bathe regularly and had to wash his own clothes. The mobile clinic he was assigned to was equipped with a hand cranked

centrifuge and an x-ray machine that did not work.

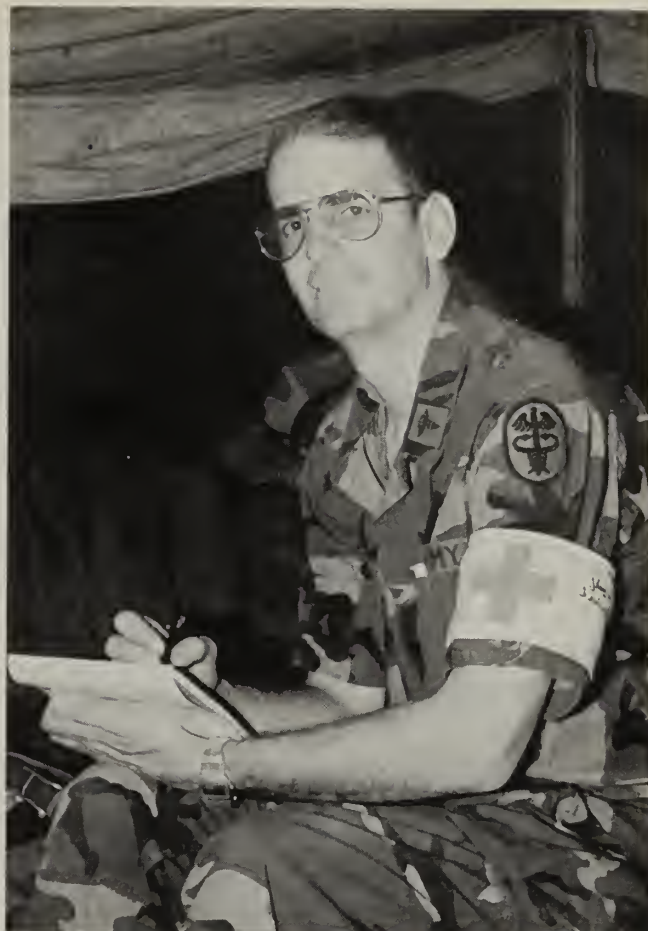
Back in Alabama Mrs. Schendal visited relatives over Christmas holidays only to return early because a plumbing leak flooded their home. She had to deal with plumbers, insurance agents, carpenters, painters and wallpaper hangers to get repairs done. "But God works in mysterious ways," she said, because she took this opportunity to repaint throughout the house herself. Keeping very busy this way she had little time to watch the live coverage of the war on television.

When the war was unofficially over, Dr. Schendal was able to call home about once a week. "AT&T would come out and set up a satellite dish in the desert for telephone calls," Mrs. Schendal relates. "The first time Michael called home he had to wait in line for six hours through a dust storm," she continues. Tanks and heavy trucks would line up in the desert as their drivers and others waited their turn to place calls. Charges for calls were discounted, but the Schendal's phone bill was still "a couple hundred dollars." Once Dr. Schendal called the office only to get the answering machine recording. Says Mrs. Schendal, "That was about a \$5 call."

Dr. Schendal was later sent to Kuwait for another month. In all, he spent three months in the area. There were just three doctors from his unit at Fort Polk who were sent to the Persian Gulf, and he never met up with any others from his local unit.

Once Schendal was able to return to Cullman in May he took little time readjusting.

He sent a letter out to all old patients and put a notice in the local newspaper announcing his return. Mrs. Schendal has always worked in his office and continues to work now that things are getting back to normal.



**Dr. Schendal in the desert.**

Jacqueline and Michael Schendal have been married for 17 years. Mrs. Schendal is the secretary-elect of the Auxiliary to the Cullman County Medical Society. They hope that the next time the reserves are called up that Dr. Schendal will not have to leave home again, but with 5 years yet to serve they will have to wait and see!



## An Effective Prescription for Your Toughest Financial Headaches...

# MONEY MASTER *Preferred*

Sometimes the price of success is the financial headaches that come along with it. If you're like many professionals, you may feel like you spend too much of your valuable time keeping track of your investments, expenses, and other financial matters.

Money Master Preferred is the professionally designed, all-in-one, asset management account that gives you:

- Monthly and annual statements that show you your entire financial world at a glance—including your net worth, budget analysis, investment analysis, tax information, and more.
- A variety of money market funds for earning daily income on your cash balance.
- Check writing privileges.
- Low-cost brokerage services for stocks, bonds, and other securities.
- Up to \$10 million account protection, of which \$100,000 can be in cash.
- A choice of two other Money Master accounts:

**Money Master Standard**—for those who do not require comprehensive asset management.

**Money Master Retirement**—an excellent choice for your qualified retirement plan.



**For more complete information about the Money Master Account that's right for you, including all fees and charges, call us now at 1-800-262-3863.**

### AMA Investment Advisers, Inc.



The Financial Services and Investment Counseling Organization Owned by the American Medical Association.

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be type-written, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.



# Advance Notice — Call For Papers

The Medical Association of the State of Alabama

## Eighth Invitational Scientific Symposium

Saturday, January 18, 1992 - 9 AM to 4 PM  
Edna Merle Carraway Convention Center, Birmingham

**Purpose of the Program**—This program is designed to allow Alabama physicians to share with their colleagues current research efforts and professional concerns. Topics selected will cover a wide range of medical interests.

**Program Format**—The program will be structured from the papers submitted by Alabama physicians. Depending on the number of papers received, topics, etc., some papers will be presented orally while others may be part of a manuscript discussion period led by a moderator. Registrants and participants will receive advance copy of all papers.

**Paper Section**—Papers will be selected using the following criteria and procedures:

1. The subject matter should be of interest to physicians in a number of specialties. Emphasis should be on medical problems which may be encountered by primary care physicians.
2. This is a program designed for and presented by Alabama physicians, so current local research efforts and professional concerns will be given top consideration.
3. The paper should be one that can be adequately outlined and covered in 20 minutes with additional time for questions. Selectees will be expected to prepare suitable written material to be used with the presentation for the study and use of the attendees.
4. On the final review of papers, members of the MASA Council on Medical Education will select topics from a variety of specialties and physician interests to offer a balanced program of general interest.

### Symposium Timetable

August 15 to October 15, 1991—Call for abstracts

October 15, 1991—Final date for abstracts to be received

Late October, 1991—Review of abstracts by the Council on Medical Education and final selection of papers

November, 1991—January 1992 - Announcement of selections, publicity and promotion of Symposium  
printing of abstracts and handouts

January 18, 1992—Program in Birmingham

**Symposium Topics**—To acquaint potential presenters with the kinds of subjects that might be suitable, the speaker and topics at the 1991 Symposium are listed below.

Robert L. Baldwin, MD—Treatment of Acute and Chronic Otitis Media in Childhood; Paul S. Howard, MD—Initial Evaluation, Primary Care and Prognosis for Children with Cleft Lip and Palate—Martin S. Cogen, MD—Clinical Evaluation of a Photorefractor for Detection of Treatable Eye Disorders in Pre-verbal Children; Guy H. Handley, MD—Evaluation and Treatment of the Patient with a Neck Mass; Steven H. Stokes, MD, et al.—Permanent Transperineal Iodine-125 Implantation as Curative Therapy for Medical Inoperable Prostatic Carcinoma; Betty Ruth Speir, MD—Atypical Cytology Mandates Colposcopy; Norman Halpern, MD, et al—Laparoscopic Cholecystectomy; Zenko J. Hrynkiw, MD—Update on Cervical Spine Disease; David W. Hodo, MD—Neuroleptic Drugs in General Practice; James C. Barton—Hereditary Hemochromatosis; James A. Kimble, MD—Diabetes 2000: Eliminating Preventable Blindness

**Abstracts**—Abstracts of the proposed paper (200-300 words, double spaced) should be sent to the Council on Medical Education

**Submission of Papers**—Interested presenters should send abstracts to the MASA Council on Medical Education. P. O. Box 1900. Montgomery, AL 36102 no later than October 15, 1991.



# A BRIGHT IDEA TO START WITH...

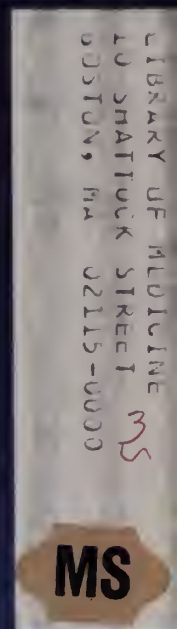


**180mg**  
**Calan<sup>®</sup> SR**  
(verapamil HCl) 180 mg  
SUSTAINED-RELEASE CAPLETS

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680



LIBRARY OF MEDICINE  
10 SHATTUCK STREET  
BOSTON, MA 02115-0000

MS

SEPTEMBER 1991 VOL. 97, NO. 3

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

## Pride

by William D. Lazenby, M.D.

FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

OCT 28 1991

## Political Flying Saucers

by S. Lon Connor



1992

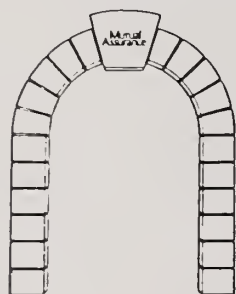


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 3, SEPTEMBER 1991

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1991 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile  
ASSISTANT EDITOR

Wm. H. McDonald, Montgomery  
ADVERTISING & DESIGN  
Rhonda Myers, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Joel C. Pittard, M.D. (1992), Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Pt. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

### EXECUTIVE DIRECTOR

S. Lon Conner  
Secretary-Treasurer - Emmett Wyatt

### DEPARTMENTS

Legal - Wendell R. Morgan  
Education - George D. Oetting  
Governmental Affairs - Richard C. Whitaker  
Public Relations - Holley Midgley  
Communications - Wm. H. McDonald

## In This Issue

Executive Director.....2  
*Political Flying Saucers*

President's Page.....6  
*Pride*

*The 'Step' Plan*.....9  
Robert T. McLaughlin, CFP

*Beyond Critical Care*.....12  
E. Gaylon McCollough, M.D., F.A.C.S.

Newly Licensed Doctors.....22

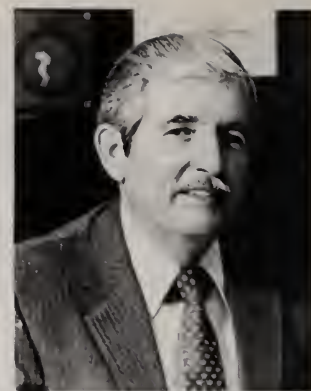
*Home Equity Lending*.....25  
C. Richard Crook, Jr.

Classifieds.....29

Auxiliary.....30  
*Travels With ORBIS*

THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA  
OCT 28 1991





*S. Lon Conner*  
*Executive Director, MASA*

## Political Flying Saucers

**I**t's 1991; do you know where your presidential candidates are?

Next year is a presidential election year. Normally by this time, you would have already been harangued for months by candidates testing the waters and sharpening their palaver for next year's primaries and sound-bite wars.

The unusual peace from these off-Broadway openings owes much to Desert Storm and the successful leadership of President Bush. Already in the catbird seat for re-election, he emerged from the Gulf war as a triumphant leader in an almost Hollywoodishly brief war that became the only conflict Americans have supported wholeheartedly since WWII. And his adroit handling of the Soviet coup was also impressive.

In a word, President Bush looks unbeatable. Only after Labor Day have there been minor seismic rumblings that the Democrats might, after all, field a credible candidate. And, some folks are saying, there is even the possibility of the president attracting competition in the Republican primaries — if only from a wild card of the disgruntled Far Right, still smarting from Bush's apostasy on taxes last year.

Okay, so we don't have the usual signs that 1992 is fast approaching. But maybe we were all looking in the wrong direction. The hustings are quiet but consider Congress and the recent spate of bills to (1) make American health care the No.1 national issue next year; and (2) to prove that the Democratic Party is still the "party with the heart." No question about it, it's already 1992 in Congress.

At the outset, let me say that the cost of American health care is a legitimate issue; no responsible leader of organized medicine denies that. Let me also say

that access to the finest health care system in the world is also a legitimate issue; no responsible leader of organized medicine denies that either.

In both, we have the usual problems of the American system — a rich offering for the many, side-by-side with a paucity for the few. That ambiguity has dogged our republic from the earliest days, not least because of the central genius of our founding philosophy: under freedom many can succeed; but under that same freedom, many will fail. The Declaration of Independence contained the seeds of the idea: it recognized only the pursuit of happiness as natural right; not the conquest of happiness.

So, the cost and access of U.S. health care are genuine national concerns. In that stipulation I hope to deflect any suggestion that, in denouncing the present bills in Congress, the thousands of doctors I serve are insensitive to the great and growing problems of the sick and the medically needy. Still, the sham and hypocrisy in the measures deserve our contempt. The authors of these phony bills are playing fast & loose with literally millions of tragedies in our society, exploiting the defenseless to fabricate political capital out of human misery.

First is the what has been called the Democratic Party's bill, introduced by Senator Teddy Kennedy, Senate Majority Leader George Mitchell, and Senator Jay Rockefeller and dubbed "Health America." The bill purports to guarantee coverage to all Americans, either through their employer or through a vastly expanded Medicaid system, called "Americare." Americare would be funded through payroll taxes and direct purchases of insurance.

Health America would require all employers either



# SYSTEMS CORPORATION

Independent Medical Systems Consultants

---

**A**t SYSTEMS CORPORATION, *we believe that computer systems should do what you pay them to do. Quietly, unobtrusively, and profitably.*

We believe *appropriate selection of software, correct installation, informative training and open-ended availability of our assistance*, coupled with your commitment, *will result in a successful system.*

Yes, we are in business to make money — *by making you money through well considered recommendations* of software and hardware for your medical practice. *As consultants, we are at liberty to recommend the very best choices to you* — the payor of our fee. We can assist you with your present system or assemble a new well-rounded computer system based on evidence pertinent to your practice.

*And guess what? We will obtain for you wholesale — or near wholesale — prices for every product we recommend.*

*What should you expect from your practice management system?*

- Comprehensiveness — before buying, be sure that a system has been well designed, well tested, and is in widespread use throughout the United States. Proprietary (home-grown) systems are simply unacceptable.
- Controls — so you can know that your practice's revenue system is working for you and that it requires your employees to do the same. This can mean real money in your pocket.
- Electronic Billing — so you can expedite your practice's cash flow and reduce billing costs.
- Expandability — so it is unlikely that you'll ever outgrow your system's capabilities.
- Customization — so that you can add special features you desire, such as medical histories accessible by you when you are not in your office.

As highly trained specialists, *we will earn your trust — and our keep.* Next time you have these kinds of things in mind — no matter the size of your need — *won't you see what we can do for you?*

SYSTEMS CORPORATION  
1-800-239-1717  
Suite 2108, First National Bank Building  
Mobile, Alabama 36602  
(In Mobile, call 432-1313)



to offer basic health insurance to their employees paid for jointly by employer and employee, or pay a payroll tax that would fund a federal Medicaid system, Americare, that would be extended to employed workers, the self-employed and families and individuals who now qualify for Medicaid.

Citizens who do not get health insurance through their employer would have to buy it from Americare. People with average incomes would pay full rates in a system that will include those parts of the population more likely to suffer illness. And, as more than one analyst has said, these rates would be very high indeed.

Health America would require that payments to physicians and hospitals be the same as those for Medicare and that hospitals and physicians taking Medicare patients must also accept Americare patients.

One liberal commentator, who calls this the "plutocrats bill," because of its Kennedy-Rockefeller backing and its obvious choice of the middle class as the group to soak for the cost, said it has the inherent vice of placing enormous premiums on Middle America while benefiting the poor at one extreme, because they would be the principal recipients, and the rich at the other, because they would be spared the chief support of Americare.

This functional flaw, which would clobber the very group most responsible for keeping our society semi-solvent, is even worse when examined in the light of the bill's failure to address cost control in any workable, meaningful way. Oh, it would provide for citizens groups cutting their own deals with doctors and hospitals, and would provide some kind of federal board to conduct negotiations to promulgate rates, but would leave it to the contending parties to adopt these rates. The board would take no part in establishing the kinds of services offered, and would not attempt to control new technology.

Most analysts view this bill as both unworkable in practice and politically counter-productive in that it would entail greater employee support for health care with reduced coverage, all for the privilege of offering a free lunch to the wealthy and the poor. State-mandated charity, you might call it. By one estimate, many employees would end up paying as much as 15% of their annual salaries for the coverage. To people on the edge of insolvency as it is, what with providing food, clothing and education for their families, this would be a crushing tax.

Workers in small businesses would have the cost of the insurance, paid through a flat-rate tax on their

employers, passed on to them in the form of lower wages. Workers forced to buy Americare might have to pay higher premiums than they would under private insurance. Small business owners themselves, already strapped, would bear proportionately higher health care costs than large corporations, the latter being favored with leverage in buying insurance. When one worker in a small business gets seriously ill, the premiums for the entire business could shoot up.

All of which is fairly typical of the Kennedy-Rockefeller mentality. To them, it's only fitting that Middle America should carry the heavy stones with which to build a monument to the benevolence and altruism of the bill's authors.

One of the alternatives to Health America has been offered by Henry Aaron of the Brookings Institution. It would establish federal and state boards that would negotiate prices and costs on behalf of the entire system. Insurance companies would be retained but only as financial conduits between the purchasers and the federal and state boards.

This plan appears to derive from certain parts of the U.S. farm program and seems as foredoomed to failure because of the built-in bureaucracy. Premiums would be based on community-wide standards rather than on age, sex, disability and the other variables insurance companies now use. What real service the insurance companies would actually perform in this new role remains unclear. They would be retained, perhaps, only to provide the protective coloration of free enterprise.

Senator Robert Kerrey and Representative Marty Russo have introduced bills that would adapt the Canadian national health insurance system to the U.S.

Canada, they say, spends about one-fourth less per capita than the U.S. while providing universal coverage. A 1990 Harvard study found 56% of Canadians pleased with their system, while only 10% of Americans were pleased with theirs, according to the same study.

Canada keeps down costs by regulating prices and restricting access. Some supporters of the Canadian system point to lower overhead north of the border. In the Canadian system there are fewer administrators than there are in the Massachusetts; the first serving 25 million, the second only 2.7 million. Also, supporters say, American administrative costs rose from 21.9% in 1983 to 23.9% of health care spending in 1987, while Canadian administrative costs declined from 13.7% to 11%.

But the drawbacks are considerable. The most

advanced technology is simply not available. Elective surgery requires long waiting periods. Finally, Americans who say that they would opt for the Canadian way if they could change their tune when asked whether they would still support such a revolution if it could be bought only at the cost of significantly higher taxes.

What this shows is that the first poll was invalid since it was not posited as costing anything. Perhaps the only surprise is that just 56% of the American public seemed to favor the Canadian way when they thought it would be free.

The U.S. health insurance industry believes that the Kennedy bill is designed as a stalking horse for national health insurance, into which it would quickly evolve. I believe this is the real objective of virtually all the proposals—to bring about by incrementalism what cannot be done honestly and above board in a single thrust.

The shame is that none of this will be presented to the public in a forthcoming manner. That is not even the intent. The intent is to launch an attack on President Bush's alleged failure to address domestic issues. The Democratic leadership has increased the pressure on this supposed weakness in the President's armor.

The bills are thus no more than early campaign tactics, probably introduced on the advice of campaign strategists feverishly searching for an issue.

It goes without saying that most Americans want anything labeled free. Offer anybody free medical care and who wouldn't be attracted?

But despite decades of trying, as assiduously as the old alchemists labored to transmute base metals into gold, liberals in Congress have failed to produce an authentic free lunch. Somebody always gets to pay the check. The shame of it is that these bills will be presented, once again, with that tired old rhetoric to the effect that somebody else will pay for your health care.

The cost to the nation will be vastly understated, as always; and the cost to the average middle-class American not stated at all.

The Greeks had a word for that: demagoguery. And that, almost by definition, is the intent of the bills so far introduced. They are a measure of the poverty of new ideas in the liberal camp, which can come up with nothing save the oldest of political shams: extravagant promises, the kind retained in our history as the graffiti of old deceptions—40 acres and a mule, pie in the sky, a chicken in every pot, every man a king, etc., etc.

# YOCON®

## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

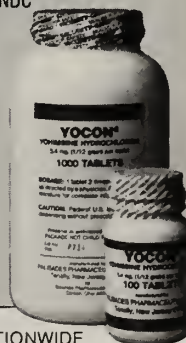
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES  
PHARMACEUTICALS, INC.**

219 County Road  
Tenafly, New Jersey 07670  
(201) 569-8502  
1-800-237-9083





William D. Lazenby, M.D.  
President, MASA

## Pride

Pride is one of those words having contradictory meanings reflecting the evolution of thought. One meaning is bad — “inordinate self-esteem; an unreasonable conceit of superiority in talents, beauty, wealth, etc.”

This kind of pride was catalogued as being the first of the seven deadly sins (the remaining six being covetousness, lust, anger, gluttony, envy and sloth), considered by the moral philosophers to be the root of all human vice.

It is the second principal definition to which this column is addressed: “a sense of one’s own worth, and abhorrence of what is beneath or unworthy of oneself; lofty self-respect; a reasonable or justifiable feeling of one’s position.”

In the heritage of Western civilization there have thus been two conflicting concepts of pride, producing this dichotomy: on the one hand worthy and dignified; on the other, arrogant contempt for lesser mortals.

Since the language grows out of human conduct and attitudes, it should be obvious that the noble kind of pride has always, throughout human history, run the risk of slipping into the ignoble. (It is this danger the Bible warns against: “Pride goeth before destruction, and a haughty spirit before a fall.”)

In his classic work, *Anatomy of Melancholy*, Robert Burton played on both meanings: “They are proud in humility; proud in that they are not proud.”

This preamble is necessary to what I feel must be the kind of pride physicians should show. I realize that there are risks involved in such an appeal to my colleagues. In asking you to be proud of your great

tradition, your calling, your own self-worth, your service to mankind, I know, as you do, that some men and women in our profession have been perverted by pride of the first kind. I certainly have no intention of approving or even condoning that.

But while we must remain ever wary of that temptation, we should cultivate the quiet, humble pride in ourselves, the institutions we have built, the great progress our predecessors have made in the long, endless fight against disease and suffering.

We must feel that same pride in what we know the future holds — even greater progress, and so on down the corridors of time. Doctors should be proud of what they have achieved for themselves and their patients. They should demonstrate this pride in noble ways; in recruiting the best and the brightest to follow our calling; by encouraging our children to follow in our footsteps if that is their desire.

We should be proud parents of children who do choose medicine, and we should not be coy about saying so. Nor should we put them and the profession down by such remarks as we have all heard: “I warned him (her) that medicine has gone down the tubes. I told him (her) that it is not the great career choice it was when I made my decision. But he (she) wouldn’t listen.”

Read again the affecting graduation address of Tommy Powell, M.D., reprinted in the August issue of *Alabama Medicine*. There you will see all the excitement, wonder, dedication, and call to service we all experienced on that signal occasion.

Encourage and foster it at every opportunity, particularly in the presence of young people. Cuss

Washington and third-party payors all you like, but don't badmouth medicine. If you have lost pride in your profession, at least don't infect others with your affliction. Bear it in silence.

Better still, seek the company of younger physicians who still have the enthusiasm and commitment you once had. Who knows, they may re-inspire you. Or take a vacation and spend some time alone on a lonely beach at dawn or sunset. Reflect on your life and what your profession has meant to you and can mean again.

Removed from the pressures of daily practice, standing aside from your frustrations and anger, you may experience an epiphany, a realization that, despite the interlopers and the red-tape artists, you have in your possession what no other labor of man can ever have — the pure joy of service to humanity, the unexampled satisfaction of returning the priceless gift of health to fellow human beings.

Have pride, the right kind, in yourself and your profession. And show it.

## MD/MEDICAL DIRECTOR

Future HealthCare, Inc., specializing in Clinical Research and Development Trials for the Pharmaceutical Industry, is seeking a part-time Medical Director for its Birmingham site.

Candidates should be board certified or eligible, preferably in Internal Medicine or with clinical experience. Contact Dr. Andrew Grubbs, Medical Director at 513-984-6868, or submit a CV to Future HealthCare, 7720 Montgomery Road, Cincinnati, Ohio 45236.

***Future  
HealthCare***  
RESEARCH CENTERS

## Term Life for Less... Much Less

They said compare, so we did.

Review these low male, non-smoker annual rates and call for quotes.

<u>AGE</u>	<u>\$250,000</u>	<u>\$500,000</u>	<u>\$1,000,000</u>
25	175*	275	500
30	175*	275	500
35	190*	305	560
40	210	340	630
45	235	385	720
50	373	635	1,220
55	525	975	1,900
60	838	1,625	3,200

All coverage is provided by companies rated A by A.M. Best Co. (Female rates lower)

Call (205) 279-8756 for quotes

**H. Ben Coker III, CLU, ChFC**  
Specialist in Life , Health & Disability

**2835 Zelda Rd #7 Montgomery, AL 36106**

\*200 minimum premium required by First International Life Insurance company





They took little sticks and touched me. It felt like a dream.



"A dream" is how Sandi Fornea described the nightmare she thought she'd never wake up from. A cheerleader and campus beauty who seemed to be living a charmed life, she felt her body gradually go numb from a rare virus. The way Sandi saw it, her paralysis had changed her whole life for the worse. And that's when the staff at

MMRC set out to change her mind.

"They respected me," said Sandi. "They didn't patronize me or treat me like a child. They taught me that if you believe in yourself, you're okay."

Sandi's illness opened her eyes to the fact that there are thousands of people like her, and made her want to do for others what the staff at MMRC had done for her.

Teaching others to believe in

themselves is what rehabilitation is all about. It's what makes MMRC the South's leading rehabilitation center.

Just ask Sandi. Today she's fully recovered, and studying to be a physical therapist.

And she'll probably tell you it feels like a dream.



**MMRC**  
MISSISSIPPI METHODIST  
REHABILITATION CENTER

1350 East Woodrow Wilson, Jackson, MS 39216  
(601) 981-2611 or 1-800-223-6672

# The 'Step' Plan

*Robert T. McLaughlin, CFP\**

**Y**ou are the manager of a multi-practitioner professional corporation and would appreciate innovative methods that would offer stability to your partnership. One concern facing your firm is the process of easing out older partners (who themselves admit to reduced productivity) by supplying significant severance pay pre-funded through ongoing tax-deductible contributions. Of course you prefer that no benefits be paid if the partner terminates voluntarily to open a competitive practice across the street.

All these concerns, i.e. additional tax relief, "golden handcuffs" fringe benefits, employee security, increasing productivity, tax-deductible funding for estate tax liabilities, etc. can possibly be addressed through the uses of a pre-funded Section 419(A) Severance Pay Plan. Unfortunately, there has not been much authority published about such programs so the business community, and its advisors, remain relatively uninformed about the subject.

Briefly, a properly-structured Severance Pay program contains the following features:

#### For the Employer:

- Pre-funding of benefits
- Tax-deductible contributions
- Employer choice of benefit levels
- Elimination of tax penalties for early withdrawal
- Co-ordination with other fringe benefit packages
- Enforceable "non-compete" clauses
- Relief from reporting, disclosure and administrative burdens
- Cost savings generated from forfeiture;s due to voluntary employee terminations

#### For the Employees and the Practitioners:

- Benefits fully-funded by the Company
- Benefit amounts of up to two times yearly compensation

- Trust protection from claims of creditors
- No government-required caps on amount of pay to be used to determine benefits
- Funds not income taxable until received
- Provisions for death benefits which can be free of income and estate taxes
- No 15% penalty on excess accumulations such as found in qualified retirement plans
- No pre-age 59 1/2 early distribution penalty nor post-age 70 1/2 mandatory distribution requirement

The Severance-Pay Plan may offer many benefits to the office manager. As an example, if Ann, an office manager, earned \$25,000 annually, then tax deductible deposits could be made to the Plan to accumulate a fund large enough to pay out as much as \$50,000 to Ann, either in a lump sum or over a 24 month period. Additionally, salary increases over time would result in higher ultimate benefits.

The following examples are situations where a severance pay program would enhance the outcome for all partners.

For example, suppose that XYZ Partnership, which had established a STEP Plan for three key employees is brought to its knees by a malpractice suit. The Company is forced to close its doors. Severance benefits would be payable, and further, not subject to creditors' liens.

Or, Dr. Rusty Scalpel, a neurosurgeon and a partner within a professional corporation of six other surgeons, loses the "touch" and cannot perform surgery any longer. His loss of proficiency causes the other surgeons to reduce his compensation. Dr. Scalpel resigns. He is eligible for benefits since his reduced capacity within the practice is beyond his control. On the other hand, if Dr. Scalpel, in the prime of his years and with all his skills intact, simply left the practice to form a new corporation on his own, no benefits would be paid since his termination would have been voluntary.

One major concern of employers and employees in

---

\*Nowlin & Associates, 2000 SouthBridge Parkway, Suite 400, Birmingham, AL 35209, 205/870-3870.



For excellent response in the treatment of  
duodenal ulcers...

# **AXID**<sup>®</sup> nizatidine has the right answers

- Rapid epigastric pain relief<sup>1,2\*</sup>
- Fast and effective ulcer healing<sup>2,3,4</sup>



**AXID**  
**PASSES THE ACID TEST**

*\*Most patients experience pain relief with the first dose.  
See adjacent page for references and brief summary  
of prescribing information.*

## AXID® (nizatidine capsules)

**Brief Summary. Consult the package insert for complete prescribing information.**  
**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlorazepate, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic, placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L). The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since marked introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumentary**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (e.g., bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperurcemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP  
[091190]

## References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol* 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request.



**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

larger Severance Pay Plans has always been the restricted "qualifying" payment events. However, recent developments now indicate that the existence of Severance Pay itself may be used as an inducement for employees (and less than 50% owners, especially in smaller multi-owner businesses or professional corporations) to terminate employment.

This induced termination, usually in the form of an "early retirement window," would be permitted as a qualifying event under the Severance Trust and thereby trigger the payment of severance benefits.

The requirements of the "window" are technical, but their existence spells a major breakthrough for pre-funded severance plans.

Since death is not considered a qualifying event, benefits would normally be forfeited by the deceased employee. However, benefits can be paid indirectly when the employer has elected to provide death benefits through insurance policies on the lives of all participants (in amounts equal to the ultimate severance benefit selected), or on only a select group of participants. In fact, the Plan could opt for insurance on the owner only (if an included participant) using the newer second-to-die policies which, if properly established under an irrevocable trust, could effectively bypass the estate of the business owner and his/her spouse.

Because there exists little reference material in Section 419(A) Severance Trusts, outside of the various complicated segments of tax law itself, advisors and business owners wishing to request additional background information may call this office at 870-3870. Lastly, the lead article in the November-December 1990 issue of the *Journal of Compensation and Benefits* contains an excellent summary of severance pay plans by its author and fringe benefit expert, Kenneth L. Katz.



# Beyond Critical Care: Appearance-Related Afflictions

E. Gaylon McCollough, M.D., F.A.C.S.\*

One hundred and fifty years ago a European physician wrote:

*"Surgery is an art concerned with the sanctity and beauty of the human form, watching over it so that, if its wonderful symmetry is damaged or disturbed it may be restored to the state in which it left Nature's creative hand."*<sup>1</sup>

For more than two thousand years medical professionals have been called upon to restore deformed or mutilated body parts. As early as 600 B.C., in India,

Hindu surgeons reconstructed amputated noses with a flap of skin transferred from the patient's forehead.<sup>2</sup>

Medical professionals not involved in the management of appearance-related afflictions, might question the motives of an otherwise healthy individual who asks to be subjected to elective surgery; but, 21st century America is a youth-oriented society which places a strong emphasis on aesthetics. Motives which drive individuals to seek appearance enhancement extend far beyond vanity. The incentive to desire surgery may cross psychological, social, and vocational lines.

As far back as the third century B.C., Aristotle recognized that, "Beauty is a greater recommendation

---

\*1600 Twentieth Street South, Birmingham, Alabama 35205, 205/930-1600.



Figure 1—This 55 year old woman underwent facelift, blepharoplasty and chin augmentation for aesthetic purposes only.



**Figure 2—**This young woman requested surgery to improve the appearance of her nose. Although the nose was only minimally too wide for her face, she had a very poor self-image. A rhinoplasty coupled with positive psychological reinforcement improved both her appearance and self-esteem.

than any letter of introduction.”<sup>3</sup>

Experts agree that, although definitions of beauty have varied through the years, the fact that favors are granted to attractive or handsome people has never changed.<sup>4</sup>

The data confirms that how an individual feels about himself impacts upon his ability to perform and function in an aesthetically-oriented international community. Some constraints are self-imposed while others are proscribed by society.

In *Overcoming Disfigurement*, Doreen Trust wrote, “Disfigurement remains the most mishandled and misunderstood of all handicaps...”, and that it “...is a condition which, all too often, strips you both of your human rights and human dignity.”<sup>5</sup>

Dr. Perry Buffington has also demonstrated that attractiveness or handsomeness influences an individual’s chance to succeed. According to Buffington, “good looks”:

1. affect grades for students
2. increase the chance at being hired

3. determine who will be one’s friends
4. decrease the stay in mental institutions.<sup>6</sup>

For a number of reasons there is an increasing desire on the part of many Americans to upgrade their appearance. Some seek surgery to look “normal;” some want to look better than normal for their age. (Figure 1)

Last year in the U.S. alone approximately 3 million people underwent aesthetic surgery in order to help improve their self-image. Many of these otherwise healthy individuals felt handicapped by their physiognomy.

The *American Heritage Dictionary* defines a “handicap,” as, any condition that “...prevents or restricts normal achievement.” The evidence is clear that one’s self-esteem plays a major role in performance.<sup>7</sup>

A minimal physical deformity can become a psychological handicap to the patient whose energies are negatively focused upon it. (Figure 2) In some cases two hours in the operating theatre may be more effec-





**Figure 3—This six-year-old child was born with deformed ears which are often a source of ridicule. An otoplasty corrected the deformity.**

tive and economical than two years of psycho-therapy.

#### *The Medical Profession's Responsibility*

People from all walks of life looking to enhance their appearance and self-image seek out specialists in the various aesthetic sciences who can help them achieve an enriched quality of life. This fact places a dual responsibility upon the medical profession.

First, training must be provided for specialists who supply these services.

Secondly, the medical community must burgeon both a consciousness and sensitivity to the needs and motivations which cause people to seek out professionals who can provide the care they desire.

Public information sources advise patients to ask their personal physician about any aesthetic surgery they are contemplating; yet, because of curriculum constraints, the average medical student's exposure to aesthetic plastic surgery is limited. This is due, in part, to the fact that, the doctor in training is challenged with volumes of information relating to the health sciences. There is simply insufficient time for a

young physician to become enlightened about every non-life-sustaining condition — even through some affect the quality of life.

Firsthand experience is also limited due to the fact that much of this branch of medicine is practiced in private offices and clinics outside traditional training centers. This trend has been necessary because, third parties do not pay for hospitalization costs relative to "cosmetic" surgery.

The following is designed to familiarize colleagues with some of the fundamental tenets of the aesthetic sciences.

#### *Who Is A Candidate For Aesthetic Surgery?*

Not everyone is an acceptable candidate for surgery; nor is surgery recommended for every patient who requests it.

The motive which impels a person to seek appearance-related surgery should be realistic. Improving one's appearance may be psychologically beneficial and help bring increased self-satisfaction and confidence. Dr. Willard Gaylin (psychiatrist from Columbia University) has concluded that, "...what a



**Figure 4—When drooping eyelid skin becomes excessive and interferes with the patient's vision, a blepharoplasty can provide improvement in both function and appearance.**

person appears to be is always a significant part of what he is.”<sup>8</sup>

The patient must understand, however, that appearance-related surgery will not save a marriage, job, or solve personal problems, particularly, if an individual blames his or her lack of success and/or happiness on “looks” alone.

The patient seeking an elective operation should be in good health. Patients are urged to see their personal physician for a check-up prior to consenting to aesthetic plastic surgery.

#### *When Is Consultation With a Colleague Indicated?*

If the plastic surgery candidate has serious health problems, the aesthetic surgeon confers with a medical colleague to confirm that the patient is an acceptable medical risk for treatment.

Aesthetic surgery has sometimes been called “psychological surgery.” The specialist who performs these services must, therefore, develop an insight into the psyche of his patients. When an underlying psychiatric problem is suspected the surgeon generally requires clearance from a colleague trained to deal with these conditions.

Conversely, when a disfigurement affects a patient's ability to function satisfactorily in society, the medical specialist might consider consultation with a surgeon. The therapist and the surgeon often

work in concert to help the disturbed patient overcome his affliction and live a more meaningful life.

#### *At What Age Can Appearance-Related Afflictions Be Corrected?*

Many congenital problems (cleft lips and palates) are repaired early. Protruding ears can be corrected by the age of 6. The child in Figure 3 underwent an otoplasty to correct abnormally shaped ears.

Deformed noses can be repaired during adolescence. Surgery to reverse the undesirable signs of aging can be performed at virtually any age providing the patient is in good health and has a life expectancy of an additional 10-15 years.

#### *What Are The Risks of Aesthetic Surgery?*

Patient dissatisfaction is one of the greatest risks. In addition to those generally associated with any type of surgery, this branch of the health sciences is graded by more subjective criteria. The patient daily evaluates the results of his or her operation and displays the surgeon's work for friends and acquaintances to critique as well. It is imperative, therefore, that both the patient and the surgeon realize the limitations of potential improvement in each case and that the patient understands and accepts the imponderables of treatment.





**Figure 5—**The man in the above photographs had a neoplasm removed from his nose. He covered the defect shown in the photograph on the left with a white gauze bandage for 20 years. The nose was reconstructed by Dr. Daniel E. Rousso with a forehead skin flap and graft from his ear.

### *Who Is Qualified To Perform Appearance-Related Surgery?*

A number of ABMS boards “certify” physicians who perform aesthetic surgery. Newer subspecialty certifying organizations provide additional “board-certification.”

Diplomates of the American Board of Plastic Surgery perform aesthetic surgery over the entire body.

The American Board of Otolaryngology certifies physicians to perform aesthetic surgery of the face, nose, head and neck.

The American Board of Ophthalmology certifies physicians to perform aesthetic surgery of the periorbital region.

Diplomates of the American Board of Dermatology perform a number of cutaneous aesthetic procedures.

Some general surgeons, orthopedic surgeons, neurosurgeons, oral surgeons and other specialists perform procedures which enhance a person’s appearance and/or sense of well-being.

More importantly than which “board” certifies the physician is the surgeon’s individual competence. Surgeons who frequently perform procedures generally develop dexterity, skills, and a perspective which translates to the individual competence indicative of the work of a specialist.

One’s ability to perform aesthetic surgery should be judged by a myriad of factors, including his artistic aptitude, knowledge, technical skills, training, character, clinical judgement, and experience. The most important criteria, however, ought to be a critical evaluation of performance — measured by a high average of consistently good post-operative results.

### *Do Third Parties Cover The Cost of Appearance-Related Surgery?*

Most health care contracts exclude surgery done solely to improve one’s appearance. When an associated “functional” problem (airway obstruction or drooping eyelids) exists, (Figure 4) third parties often pay for the portion deemed “medically necessary.”

Restorative or reconstructive surgery which is per-

# EIGHT GOOD REASONS TO SWITCH HEALTH INSURANCE COMPANIES

---

## 1 LOW RATES

*Compare our premiums to what you're paying now*

## 2 CHOICE OF DEDUCTIBLES WITHIN YOUR GROUP

*Mixing deductibles within your group can help control expenses*

## 3 PERSONAL SERVICE

*We're large enough to meet your needs - yet small enough to care*

## 4 A TRADITION OF TRUST

*We've been serving health care professionals exclusively since 1978*

## 5 AN A+ FOR FINANCIAL STRENGTH AND STABILITY

*Affiliated with Mutual Assurance, rated A+ by A.M. Best*

## 6 A CHOICE OF PROVIDERS

*Total freedom to choose the doctors you want to use*

## 7 RAPID CLAIMS HANDLING

*Most claims paid within two weeks*

## 8 NO PRE-CERTIFICATION REQUIRED

*No administrative headaches or hassles for you or your family*

IF YOU THINK THESE ARE GOOD REASONS  
CALL 1-800 344-9588

**LifeSouth**

PROFESSIONAL'S HEALTH PLAN





**Figure 6—13-year-old girl with extremely large breast withdrew from school and society because she was self-conscious about her breast. Her breast reduction was performed by Dr. Peter Van Hoy in associated with the F.A.C.E. Foundation and Children's Hospital pro bono.**

formed in an attempt to correct a congenital defect, deformity resulting from an accident or cancer extirpation, or to improve the function of a physically altered body part generally falls under covered expenses. (Figure 5)

#### *How Can Patients Be Helped Who Need Plastic or Reconstructive Surgery but Cannot Afford It?*

Pro bono services may be provided through private foundations, teaching centers, some social agencies, and individual practitioners as well.

Additional information can be obtained through the Medical Association of the State of Alabama. Individuals and institutions interested in helping should notify MASA or their county medical society. The patient whose photographs are shown in Figure 6 received pro bono services.

#### *What Technological Advances Have Been Incorporated Into The Aesthetic Sciences?*

Computers are part of new technology which help surgeons analyze body features and make recommendations for correction. For most procedures the patient is able to visualize (on a special television screen) the anticipated changes in the structure of body parts. (Figure 7)

Lasers are helpful in removing certain types of birthmarks and superficial skin conditions.

Advancements in life-support equipment make it possible for outpatient surgical facilities to provide cost-efficient, care-effective care for patients undergoing elective procedures.

#### *Why Do Most Patients Elect to Have Aesthetic*

#### *Surgery Done Outside Hospitals?*

This decision is driven by costs. When the operation is purely one of aesthetics the patient, not his insurance company, bears all expenses associated with treatment. Operating room, facility, and recovery costs at most hospitals generally run three or four times that of comparably equipped private office surgical suites.

A number of reconstructive, restorative, and "functional" procedures are included in third party contracts and may be performed at a hospital. (Figures 8 & 9)

#### *Is Silicone Safe To Use in Aesthetic Surgery?*

Silicone is an "ideal biocompatible soft tissue augmentation implant" because it is thought to be "physio-chemically inert."<sup>10</sup> For this reason, it is used throughout the medical industry.



**Figure 7—Computer imaging assists the surgeon in counseling patients about anticipated changes in their appearance.**

# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM \$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

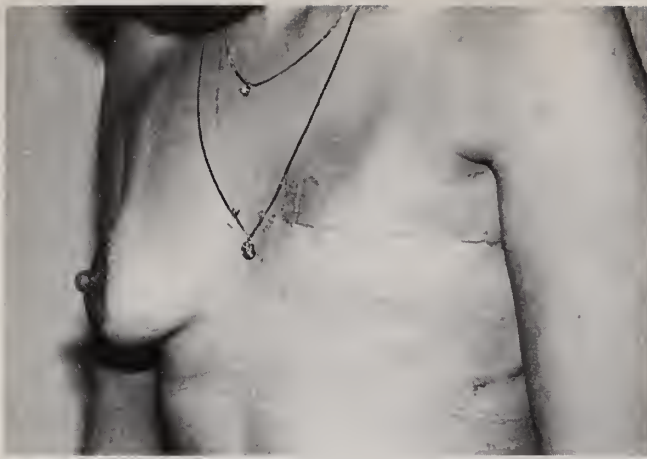
**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**





**Figure 8—**This 38-year-old woman underwent a mastectomy for breast cancer. Her left breast was reconstructed and a mastopexy (breast lift) was performed simultaneously on her right breast by Dr. George R. Duquette.

Some medications contain derivatives of silicone. Because it is tolerated well by the body, it is also placed as a lubricant on needles, catheters, and invasive equipment. From the needles and syringes he or she uses the average elderly insulin-dependent diabet-

ic deposits 5 cubic centimeters of silicone in their body each year — considerably more than would ordinarily “leak” through the walls of an implant used in breast surgery.

In humans, there is no hard evidence that silicone



**Figure 9—**This patient developed Rhomberg's hemifacial atrophy as a young adult. The shape of her face was restored by using multiple mesh and silicone implants.



**Figure 10—**Facial harmony can be balanced with multiple procedures, including face and neck lift, eyelid lifts, rhinoplasty and chin augmentation. All these procedures were performed at the same time on this patient in a private office outpatient surgical suite.

causes cancer, auto-immune disease, or mental aberrations.<sup>11</sup>

#### *How Do Patients Obtain Information About the Aesthetic Sciences and The Surgeons Who Practice Them?*

A number of medical organizations provide literature at no charge to the public, including:

The American Academy of Facial Plastic and Reconstruction Surgery (1-800-332-3223), The American Society of Plastic and Reconstructive Surgeons (1-800-635-0635), The American Society of Cosmetic Surgeons (1-800-221-9808) and the American Society of Dermatologic Surgeons (1-708-869-3954).

#### **Summary**

There is no reason to believe that humans will not continue in their never-ending quest for self-fulfillment, for in it mankind carries forward the purpose of

life itself.

Through the art and science of aesthetics, specialists throughout the various health professions are co-operating to help individuals from all socio-economic backgrounds overcome appearance-related afflictions and improve the quality of life. (Figure 10)

#### **References**

1. *Zeis Index*, Volume 1, (Baltimore MD.: Williams and Wilkins Co, 1977), p. xxx
2. Trust, Doreen, *Overcoming Disfigurement*, (Thorsons Publishing Co., 1986), pp. 32, 61
3. Buffington, Perry W., Ph.D., "In the Eye of the Beholder", *Delta Airlines Sky Magazine*, (Halsey Publishing Co., 1990)
4. *Ibid.*
5. Trust, p. 15
6. Buffington
7. *American Heritage Dictionary*, Second Edition, (Boston, Mass: Houghton Mifflin, Co., 1982)
8. Eigen, Lewis D. and Seigel, Jonathon, *The Manager's Book of Quotations*, (Amacom), p. 386
9. *Dermatologic Surgery*, ed. Roenigk and Roenigk, (New York, NY: Marcel Dekker Inc., 1989), p. 1349
10. *American Heritage Dictionary*
11. Orentreich, Norman, M.D. New York, NY, Personal Communication
12. Maltz, Maxwell, M.D. *Psycho-cybernetics and Self-Fulfillment*, (Bantam, 1973)



# Newly Licensed Doctors

Brown, Terry Michael, M. D.  
VAMC - Uptown  
116 AU -1 Freedom Way  
Augusta, GA 30909

Hill, Darnita Anderson, D . O .  
Etowah Quality of Life  
Department Family Practice  
1117 Tuscaloosa Avenue  
Gadsden, AL 35901

Buckner, Lynn Randolph, M. D.  
UAB / Department General Surgery  
UAB Station  
Birmingham, AL 35294

Whitley, James Peter, M. D.  
Family Practice Center  
7833 2nd Avenue South  
Birmingham, AL 35206

Callahan, Karen Elaine, M. D.  
3809 12th Court South, #D-1  
Department Psychiatry  
Birmingham, AL 35222

Willis, Albert Edward, M. D.  
UAB/Dept. Oral - Maxillofacial Surgery  
UAB Station, School of Dentistry  
Birmingham, AL 35294

Freant, Lawrence Joseph, M. D .  
1601 Hillcrest Road, Apt. 72  
Department Pathology  
Mobile, AL 36695

Krecker, Martin Thomas, M. D.  
2008-A North Portier Court  
Department Surgery  
Mobile, AL 36607

Allport, Frederick William, M . D .  
Searcy Hospital / Psychiatry  
1504 Springhill Avenue  
Mobile, AL 36604

Archibald, Glenn Orlando, M. D .  
3490 Independence Drive  
Department Psychiatry  
Birmingham, AL 35209

Barrow, Mary Alice, M. D .  
4240 Narrow Lane Road  
Internal Medicine Program  
Montgomery, AL 36111

Birdwell, Thomas Rogers, M. D.  
123 Seamarge Circle  
Department Pathology  
Pensacola, FL 32507

Black, Hugh Ratchford, M. D.  
Children's Hospital of Alabama/Pediatrics  
1600 6th Avenue South  
Birmingham, AL 35233

Claytor, Tonya Cottrell, M. D.  
121-A Greenlawn Drive  
Department Family Practice  
Lebanon, TN 37087

Cotliar, Rochelle, M. D.  
UAB/Spain Rehabilitation Center  
UAB Station - SRC 190  
Birmingham, AL 35233

DeArment, Randall L., D.O.  
1460-A 2nd Avenue, SW  
Box 340  
Jacksonville, AL 36265

Dobson, Joseph Van Lear, M. D.  
Children's Hospital of Alabama  
1600 7th Avenue South  
Birmingham, AL 35233

Edwards, John Lee, M. D.  
3305 Crane Ferry Road  
Department Ob-Gyn  
Augusta, GA 30907

Frenette, Luc, M. D.  
UAB / Department Anesthesiology  
619 South 19th Street  
Birmingham, AL 35233

Gad, Nabil Morshed, M. D.  
USA Knollwood Park Hospital  
3421 Medical Park Drive West  
Suite 2  
Mobile, AL 36693

Grigsby, Benson A., M. D.  
7692 Timberdale Drive  
Family Practice/General Medicine  
Columbus, GA 31909

Hall, Russell David, M. D.  
2304 Teton Road  
Department Internal Medicine  
Birmingham, AL 35216

Hawkins, Mark Douglas, M. D.  
783 Hedgelawn Way  
Fayetteville, NC 28311

Hendrix, Ronnie Eugene, M. D.  
UAB/Department Emergency Medicine  
619 South 19th Street  
Birmingham, AL 35233

Hull, Jeffrey Wayland, M. D.  
5514 Wooldridge Road  
Corpus Christi, TX 78413

Ingham, Denise Ann, M. D.  
101 Court Street, #801  
Evansville, IN 47708

Jackson, Michael DeLano, M. D.  
Perry County Hospital /General Practice  
P.O. Box 149  
Marion, AL 36756

Jett, Stanley Wayne, M. D.  
320 East Coosa Street  
Department General Practice  
Talladega, AL 35160

Johnson, Victoria Anne, M. D.  
UAB / Division Infectious Diseases  
1900 University Boulevard, Room 229-TH  
Birmingham, AL 35294

Kelly, Kevin Thomas, M. D.  
3226 West Main Street, Suite 101  
Department Ophthalmology  
Dothan, AL 36301

Kennedy, Colleen Marie, M. D.  
Lloyd Noland Hospital/Internal Medicine  
701 Lloyd Noland Parkway  
Fairfield, AL 35064

LaRussa, Joseph Bruno, M. D.  
The Children's Hospital of Alabama  
1600 7th Avenue  
Birmingham, AL 35233

Mays, Therese Evans, M. D.  
Carraway Methodist Medical Center/IM  
1600 North 26th Street  
Birmingham, AL 35234

McMicken, David Bruce, M. D.  
UAB/Department Emergency Medicine  
619 South 19th Street  
Birmingham, AL 35233

Nieto, Jose Galileo, M. D.  
722 Stone Avenue  
Department Internal Medicine  
Talladega, AL 35160

Palkar, Neelkanth Vishnu, M. D.  
USAMC / Department Anesthesiology  
2451 Fillingim Street  
Mobile, AL 36617

Panuccio, Denise, M. D.  
313 Church Avenue, NE  
Department Internal Medicine  
Jacksonville, AL 36265

Plessala, Kirby James, M. D.  
UAB/Department Ob-Gyn  
UAB Station, Room 443 OHB  
Birmingham, AL 35294

Ranjan, Ratnabali, M. D.  
3600 Oakdale Drive  
Birmingham, AL 35223

Sams, John Elliot Polson, D. O.  
2067 Springhill Avenue, 162-B  
Family Practice, Anesthesiology  
Mobile, AL 36607

Schmitt, Lee Aubrey, M. D.  
1106 Woodland Village  
Department General Surgery  
Birmingham, AL 35216

Shutter, Lori Anne, M. D.  
UAB/Department Neurology  
UAB Station  
Birmingham, AL 35294

Simaytis, Christine Judith, M. D.  
VA Medical Center /Internal Medicine  
215 Perry Hill Road  
Montgomery, AL 36109

Singer, Patricia Gerr, M. D.  
UAB /Medical Education Building



UAB Station, General Internal Medicine  
Birmingham, AL 35233

Sirna, Charles Thomas, M. D.  
801 Gaines Avenue, #306  
Internal Medicine/Cardiology  
Gadsden, AL 35903-1141

Steinmetz, Stephen Richard, M. D.  
3725 Shamley Circle  
Birmingham, AL 35223

Stephens, Ronald Todd, M. D.  
Noble Army Hospital  
Department of PCCM  
Ft. McClellan, AL 36205

Strickland, Johnnie Wayne, Jr., M. D.  
175 Leisure Drive  
Monroe, LA 71203

Tatapudy, Meera, M. D.  
USAMC / Department Pediatrics  
2451 Fillingim Street  
Mobile, AL 36617

Thagard, Roy Frank, M. D.  
P.O. Box 1241  
Sea Island, GA 31561

Ulin, Louis S., M. D.  
6050 34th Street West, Apt. 707  
Bradenton, FL 34210

Windham, Katherine Booty, M. D.  
4240 Narrow Lane Road  
Internal Medicine Residency Program  
Montgomery, AL 36111

Wingo, Kathy Renee, M. D.  
1729 Oxmoor Road  
Department Pediatrics  
Birmingham, AL 35209

Woodall, John Burleson, M. D.  
Neonatal Associates, PA  
2119 East South Boulevard, Suite 101  
Montgomery, AL 36116

Yonehiro, Layne R., M. D.  
121 Camphor Avenue  
Department Surgery  
Foley, AL 36535

Troup, Paul James, M. D.  
1835 Kelly Lane

Brookfield, WI 53045  
After 10/01/91:  
880 Montclair Road - First Floor  
Department Cardiology  
Birmingham, AL 35213

Davis, Steven James, D. O.  
511 Brantley Street  
Department Family Practice  
Opp, AL 36467

Ashford, William Clay, M. D.  
815 East University Boulevard, Suite C  
Department Ophthalmology  
Tuscaloosa, AL 35401

Harrington, Randall Leon, M.D.  
USAMC/Department Surgery  
2451 Fillingim Street  
Mobile, AL 36617

Leidel, George David, M. D.  
2501 Harn Boulevard, J-14  
Clearwater, FL 34624

## EMERGENCY MEDICINE

### *BIRMINGHAM*

#### *MEDICAL DIRECTORSHIP AND STAFF PHYSICIAN OPPORTUNITIES*

EMSA Limited Partnership is proud to announce our new affiliation with TWO of Alabama's finest institutions. As a result of this expansion, ground floor opportunities exist for a Medical Directorship and several staff positions.

Medical Director candidates must be Board Certified in Emergency Medicine. Staff physician candidates must be Board Prepared in a Primary Care Specialty with significant Emergency Medicine experience.

Choose an academic setting or a busy growing suburban practice.

- \* Outstanding compensation
- \* Paid malpractice insurance
- \* 401(k) options
- \* CME programs
- \* Career track opportunities
- \* Paid medical-life-disability insurance

Call James Krienen 24 hours a day at (800) 443-3672 ext. 245 or FAX your C.V. to (305) 792-3531 or mail to EMSA Limited Partnership, 100 N.W. 70th Ave. Fort Lauderdale, Florida 33317 EEO/AA/M/F

# Home-Equity Lending: A Semi-New Ball Game

C. Richard Crook, Jr.\*

**Y**ou want to buy a new car, so you need to borrow \$35,000. On a signature or personal loan secured by the car, the rate you get from your bank may be, say, 10%. In one year, if you pay back no principal, you'll pay about \$3,500 in interest.

However, it's 1991, and the last consumer loan interest tax deduction left to us is the interest we pay on loans secured by our homes. Look at the difference it can make.

Using a home-equity loan, about a third of that amount will be tax-deductible on your next year's return. So, you'll end up paying only about \$2,335; on your \$35,000 loan — an effective interest rate of 6.67%.

Maybe it's time to give these home-equity loans a closer scrutiny. In this article, we focus on the advantages of home equity loans, ways to make them even simpler and easier for you and a few caveats.

There are two forms of home-equity loans, closed-end loans and home-equity lines of credit. The closed-end loan has been around for years, going by the name of "second mortgage."

Traditionally, second mortgages were used for home improvements, and the borrowed amount, a lump sum, was paid back over a set period, usually 10 years. This kind of loan is still available and still tax deductible up to \$100,000 in most circumstances.

A home-equity line of credit, on the other hand, is more akin to having a gold/platinum/titanium credit card, without the card. On the front end, you'll pay a fee for it and plough through some paperwork. Once it's established, however, it's a flexible way to borrow money quickly. Usually, borrowing becomes as simple as writing a check.

If you itemize deductions, normally the interest on home equity loans of up to \$100,000 will remain 100% deductible on Federal Form 1040. This is making home-equity lines of credit an increasingly popular choice when people borrow money; *TIME* magazine (11/19/90) points out that they grew about 27%

last year, much faster than other kinds of consumer borrowing.

And they're flexible. You can use a home-equity line of credit for dozens of things. According to *Consumer Reports* (November 1990), home improvements are still the most popular reason for home-equity loans (including line of credit borrowing), accounting for 30% of the total and debt consolidation are almost tied for second place, comprising 15 and 14% of the loans respectively. Education (10%), medical expenses (8%), vacations (6%) and business needs (4%) follow in popularity, with 13% categorized as miscellaneous.

For big-ticket borrowing, using a home-equity line of credit makes more sense than using a credit card. The deductibility of the interest aside, you'll be paying a better rate of interest to begin with. Most banks charge a variable rate that ranges from 1.5 to 2 points over the prime, which is more responsive to interest trends and therefore more volatile, but still a better deal than rates charged by credit cards.

For these reasons, Mike Solomon, vice president, real estate loans for First Alabama Bank in Montgomery, says that frequently a physician's business manager will suggest using a home-equity line of credit to finance special projects, like short-term investments in the stock market or the purchase of a boat.

"Time is the physician's most valuable commodity, and a line of credit secured by home equity saves a lot of time, as well as saving interest," Solomon points out.

Solomon suggests that we check with our tax advisors to be sure the interest expense is completely deductible.

Some homes have appreciated in value much faster than others over a period of years. Interest deductibility is related to the original purchase price plus the improvements made to the property since the purchase. Also closing costs, such as points charged up front, are not generally deductible on home equity loans as they are on conventional mortgage loans. These factors should be discussed.

---

\*Vice President, First Alabama Bank, P.O. Box 511, Montgomery 36134, 205/832-8257.



Another caveat that deserves attention is this: households laden with both first- and second-mortgage debt risk financial disaster if times get hard. A disabling accident or a heavy slump in the real estate market are possibilities that have to be considered before putting your home equity on the line.

### How Much Can You Borrow?

In 1989, some banks would lend you up to 85% of your equity in your home. Today, few financial institutions will let you extract more than 80% of the value of your home, and most conservative banks hold that number to 75%. Calculation looks like this:

	<u>Example</u>	<u>Your Home</u>
Appraised Value	\$200,000	_____
Multiply by 75%	x .75	x .75
Total	\$150,000	_____
Minus Balance of Your Mortgage	- \$70,000	_____
Your Potential Borrowing Power	\$80,000	_____

While some banks have been allowing debt payments—mortgage, credit cards, home equity line of credit payments—to total as much as 43% of monthly gross income, Alabama banks are more conservative. First Alabama Bank, for example, doesn't like to see more than 32% of a physician's gross monthly income going to debt payments.

Another consideration: while many lenders require only interest payments during the life of the credit line, you may want to prepay some principal. If not, you could face a large balloon payment a decade or so down the road.

To most physicians, saving time is as important as saving money. You'll save yourself both in the long run by putting a little effort into knowing your banker from the beginning, and ensuring that he or she knows you and your situation well.

Another advantage of getting to know your banker is not having to go from one banker to another to get what you need. You won't have to establish yourself as a valued customer with four different people to cover all your banking requirements.

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be type-written, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.



## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association





Help reduce breast cancer deaths by  
at least **25** percent ...

**Refer your female patients  
for regular screening mammograms**

Twelve major medical organizations recommend that asymptomatic women ages 40-49 should have a screening mammogram every 1-2 years, and a physician's examination every year. Asymptomatic women 50 and older should have a mammogram and a physician's exam every year.

Scientists estimate that if women followed these guidelines, breast cancer deaths would **decline** by at least **25** percent.



1599 Clifton Rd., N.E.  
Atlanta, GA 30329



1891 Preston White Drive  
Reston, VA 22091



# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

**BIRMINGHAM ALABAMA**—Future Healthcare Research Center is seeking a part-time Medical Director for its Birmingham site. For more information see ad on page 7.

**FPS and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA.** Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**ER PHYSICIANS NEEDED** for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**ALABAMA**—Emergency career opportunities available in Birmingham, Boaz, Foley, and Valley, Alabama. ED volumes range from 12,000 to 30,000 visits annually. For more information please send your CV to Lynda Holland, Coastal Emergency Services of Birmingham, Inc., One Perimeter Park South, Suite 430N, Dept. SO, Birmingham, AL 35243 or call toll-free 1-800-878-4210.

**PSYCHIATRY**—Unique and immediate ground-level opportunity for two (2) aggressive and energetic BC/BE Psychiatrists. Established office practice with large referral base offers general psychiatry, geriatrics, substance abuse programs, family, marital and group therapy, and we will develop additional programs. Highly competitive compensation, liberal benefits including professional liability, and opportunity for full partnership. Send C.V., or direct inquiries, to Bill Mylius, Norwood Clinic, P.O. Box 830230, Birmingham, AL, 35283 (205)250-8903.

**ORTHOPEDIC SURGERY**—Two (2) positions available immediately for BC/BE Orthopedic Surgeons at a major multispecialty clinic in Birmingham. Active general office practice (primarily adult) with a broad referral base and exclusive coverage of 600-plus bed medical center. Highly competitive compensation, liberal benefits including professional liability, and opportunity for full partnership. Send C.V., or direct inquiries, to Bill Mylius, Norwood Clinic, P.O. Box 830230, Birmingham, AL 35283 (205)250-8903.

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

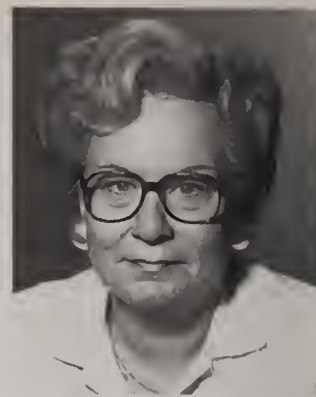
Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

**P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992**

Above rates are provided by Jackson National Life





*Mrs. Stuart K. Bean  
A-MASA, President*

## Travels With ORBIS

*Michael A. Callahan, M.D.  
(edited by: Donna K. Specker)*

(The following is Dr. Michael A. Callahan's account of his trip to India with ORBIS, a non-profit international missionary organization dedicated to fighting blindness world-wide. Dr. & Mrs. Callahan, who live in Birmingham, have been active with the group for several years and are now planning a seventh trip through Central and South America.)

Prescription for an ORBIS "vacation": Take a 30 hour air flight halfway around the world, almost immediately start seeing clinic patients, operate five days a week for two weeks, keeping 12-hour days, then return home. Would anyone want to relax and recharge their mental battery this way? I did and enjoyed it tremendously!

In June 1989, my wife and I accepted an invitation to travel to New Delhi, India, for a two-week stint where I performed eye surgery with ORBIS.

Project ORBIS is dedicated to fighting blindness worldwide through health education and hands-on surgical skills training in ophthalmology. Since its inception in March 1982, ORBIS has held more than 110 three-week programs in 60 countries. The programs primarily take place inside the ORBIS aircraft, which is a DC-8 jet converted into a fully equipped eye surgery hospital and teaching facility.

ORBIS was the brain-child of Dr. David Paton, a Houston ophthalmologist who saw a need to help those in foreign countries keep abreast of new technology and techniques. It is now a worldwide organization with offices in New York, Houston, London

and Hong Kong.

In its first year more than 1200 host-country doctors participated in the ORBIS program and approximately 87 ophthalmologists from the United States donated their time away from their practices and academic responsibilities to share their experiences and expertise. This trend has continued and increased every year. ORBIS now provides teaching and support that touches literally thousands of lives.

The ORBIS plane, which was donated by United Airlines, flies to a visiting country and is moored at the airport where all surgery is done. The original first-class section of the aircraft has been converted into a classroom with a large projection TV monitor and screen. Adjacent is an examination room where pre and postoperative patients can be examined and various types of laser work performed. The operating room, separated from the classroom by a semi-sterile area and surgical scrub area, is fully equipped for performing oculoplastic, retinal, cataract, or corneal transplantation surgery. Seven strategically located video cameras document surgical maneuvers from practically any angle, in addition to a camera which is connected to the operating microscope. The "brain" of the entire teaching program consists of a highly sophisticated audio and video center located near the center of the aircraft that relays the surgical action to the TV monitors in the classroom or sometimes a nearby university.

ORBIS does not visit countries haphazardly or randomly. More than one year of planning goes into each trip to a foreign country. Not only must the government and medical ministries whole-heartedly endorse

# AM HIGH

## PUT YOUR MEDICAL CAREER IN FLIGHT.

Discover the thrill of flying, the end of office overhead and the enjoyment of a general practice as an Air Force flight surgeon. Talk to an Air Force medical program manager about the tremendous benefits of being an Air Force medical officer:

- Quality lifestyle, quality practice
- 30 days vacation with pay per year
- Support of skilled professionals
- Non-contributing retirement plan if qualified

Discover how to take flight as an Air Force flight surgeon. Talk to the Air Force medical team today. Call

**USAF  
HEALTH PROFESSIONS  
1-800-423-USAF  
TOLL FREE**





the ORBIS mission, but local doctors must be willing to work with the ORBIS physicians to provide support in their local hospitals and clinics. They must also agree to comply with ORBIS' rigid preoperative work-up schedules and postoperative questionnaires so that follow-up data can ORBIS be collected on the patients operated on through the ORBIS program.

Visiting doctors can sign up to join the ORBIS airplane at a specific city on a specific date. Usually two visiting doctors, each with a different subspecialty interest, will join the ORBIS team of ophthalmologists, anesthesiologists, nurses, and technicians by flying commercial airlines (usually at their own expense). The visiting doctor must be comfortable in operating in a teaching environment with people asking questions (usually through interpreters) at any and all stages of the procedure. It helps if one is able to tolerate strange food and recover from jet-lag quickly!

With this in mind, Teresa and I excitedly planned our trip to New Delhi. Since we would be traveling to an area where cholera, small pox, and yellow fever were endemic, the appropriate vaccinations were required before obtaining our visas. On the day we were to receive the inoculations Teresa's motherly intuition prompted her to have a second pregnancy test just one week after the first negative one. Although we were overjoyed that the second test was positive, thus indicating that Charles Michael Callahan would be joining us in nine months, we made the decision that Teresa should not undergo the inoculations, leaving me to go on the project to New Delhi by myself.

After flying for over a day and a half, I landed in New Delhi at approximately 4 a.m. Saturday. The government had provided rooms for the entire crew at the Oberi Hotel but, although the bed certainly looked very enticing after a long journey, I was either too tired or too excited to sleep. Saturday was a rather slow day and after some sight-seeing Saturday afternoon and Sunday morning we traveled in a mini-van to the clinic Sunday afternoon to examine and screen patients for surgery the following week.

Patients are selected primarily according to need and severity of the illness, while keeping in mind that as many different diseases as possible should be treated to maximize the teaching value of the project. Obviously there are many patients in dire need that do not fulfill these criteria, and they were operated on at a local hospital by me and one of the host doctors without the classroom situation.

A typical day would last from 6:30 a.m. to 7 p.m. with the time taken up by examinations, lectures, per-

forming surgery and postoperative visits. Several nights the ORBIS crew was invited to local doctors' houses and on one special occasion the Minister of Health of India hosted a banquet for us.

Although I was greatly stimulated by the surgery and teaching on the ORBIS airplane, I found operating in the local hospital equally as challenging. The hospital facility was neat but antiquated by our standards. The equipment was in good working order but not what we are accustomed to in the United States. Even the doctors' dressing room exuded frugality, consisting of a tiled room with a six-foot curtain that could be drawn for privacy and hooks on the wall for hanging our clothes.

The ophthalmologists that I met in New Delhi were as bright, intelligent, and hard working as any I've met in the United States. It is not unusual for Indian doctors to work 14-16 hours a day, six days a week or months at a time without vacation. Generally they live on the hospital grounds with their wives and families; this includes both residents and attending physicians. While lacking many of the modern supplies and conveniences, they are well aware of the latest articles published in our journals and were able to cite literature by volume and page number. They handled patients about the same way we do here; and this, along with the other experiences I had in India, cemented our humanitarian bonds as international colleagues.



# Advance Notice — Call For Papers

The Medical Association of the State of Alabama

## Eighth Invitational Scientific Symposium

Saturday, January 18, 1992 - 9 AM to 4 PM  
Edna Merle Carraway Convention Center, Birmingham

**Purpose of the Program**—This program is designed to allow Alabama physicians to share with their colleagues current research efforts and professional concerns. Topics selected will cover a wide range of medical interests.

**Program Format**—The program will be structured from the papers submitted by Alabama physicians. Depending on the number of papers received, topics, etc., some papers will be presented orally while others may be part of a manuscript discussion period led by a moderator. Registrants and participants will receive advance copy of all papers.

**Paper Section**—Papers will be selected using the following criteria and procedures:

1. The subject matter should be of interest to physicians in a number of specialties. Emphasis should be on medical problems which may be encountered by primary care physicians.
2. This is a program designed for and presented by Alabama physicians, so current local research efforts and professional concerns will be given top consideration.
3. The paper should be one that can be adequately outlined and covered in 20 minutes with additional time for questions. Selectees will be expected to prepare suitable written material to be used with the presentation for the study and use of the attendees.
4. On the final review of papers, members of the MASA Council on Medical Education will select topics from a variety of specialties and physician interests to offer a balanced program of general interest.

### Symposium Timetable

August 15 to October 15, 1991—Call for abstracts

October 15, 1991—Final date for abstracts to be received

Late October, 1991—Review of abstracts by the Council on Medical Education and final selection of papers

November, 1991—January 1992 - Announcement of selections, publicity and promotion of Symposium  
printing of abstracts and handouts

January 18, 1992—Program in Birmingham

**Symposium Topics**—To acquaint potential presenters with the kinds of subjects that might be suitable, the speaker and topics at the 1991 Symposium are listed below.

Robert L. Baldwin, MD—Treatment of Acute and Chronic Otitis Media in Childhood; Paul S. Howard, MD—Initial Evaluation, Primary Care and Prognosis for Children with Cleft Lip and Palate—Martin S. Cogen, MD—Clinical Evaluation of a Photorefractor for Detection of Treatable Eye Disorders in Pre-verbal Children; Guy H. Handley, MD—Evaluation and Treatment of the Patient with a Neck Mass; Steven H. Stokes, MD, et al.—Permanent Transperineal Iodine-125 Implantation as Curative Therapy for Medical Inoperable Prostatic Carcinoma; Betty Ruth Speir, MD—Atypical Cytology Mandates Colposcopy; Norman Halpern, MD, et al.—Laparoscopic Cholecystectomy; Zenko J. Hrynkiw, MD—Update on Cervical Spine Disease; David W. Hodo, MD—Neuroleptic Drugs in General Practice; James C. Barton—Hereditary Hemochromatosis; James A. Kimble, MD—Diabetes 2000: Eliminating Preventable Blindness

**Abstracts**—Abstracts of the proposed paper (200-300 words, double spaced) should be sent to the Council on Medical Education

**Submission of Papers**—Interested presenters should send abstracts to the MASA Council on Medical Education, P. O. Box 1900, Montgomery, AL 36102 no later than October 15, 1991.



# A BRIGHT IDEA TO START WITH...



MS

**180mg**  
**Calan<sup>®</sup> SR**  
Verapamil HCl  
SUSTAINED-RELEASE CAPLETS

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

# Alabama Medicine

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

# ACCOUNTABILITY

FRANCIS A. DEUNTWY  
LIBRARY OF MEDICINE  
BOSTON, MA

DEC 03 1991

**"The good doctor  
is accountable to  
his patient,  
to himself and  
to his profession"**

**- William D. Lazenby,  
M.D.**

**Page 6**

**• Failure of a Model  
- S. Lon Conner Page 2**

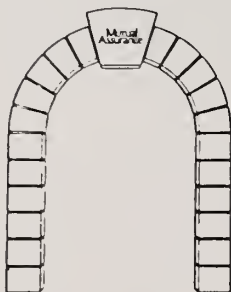


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 4, OCTOBER 1991

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery  
Alabama 36102-1900. Subscription Prices: member, \$15.00,  
non-member, \$30.00 per year \$2.50 per copy. Second class  
postage paid at Montgomery, Alabama and at additional offices.  
Published monthly by The Medical Association of The State of  
Alabama at 19 South Jackson Street, Montgomery, Alabama  
36104.

POSTMASTER: Send address changes to Alabama Medicine,  
P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association  
of the State of Alabama for open and responsible discussion of  
matters relevant to medicine and other fields of interest to physi-  
cians. Conclusions and opinions expressed herein are those of the  
individual authors. No portion of this publication may be repro-  
duced in any form, including electronic, without written consent.  
Publishers reserve the right to reject any advertising with or with-  
out explanation.

Copyright 1991 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Myers, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D.  
Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W.  
Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President -  
T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President -  
Joz C. Pittard, M.D. (1992), Opelika; Speaker, House of  
Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*,  
Birmingham; Vice-Speaker, House of Delegates - R. Bob  
Mullins, M.D. (1994)\*\*\*, Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL  
ASSOCIATION (Terms expiring December 31 of year shown)  
1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C.  
Yohn, M.D., Eufaula. 1992 Delegates - Julius Michelson, M.D.,  
Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr.,  
M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D.,  
Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W.  
Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D.,  
Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile;  
Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D.,  
Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar  
W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D.,  
Chairman (1992), 3rd District, Anniston; Richard H. Esham,  
M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D.  
(1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Pt.  
Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton;  
William C. Waller, M.D. (1992)\*, Montgomery; William M.  
Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr.,  
M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D.  
(1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District,  
Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James  
H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D.,  
Montgomery.

## - STAFF -

## EXECUTIVE DIRECTOR

S. Lon Conner

Secretary-Treasurer - Emmett Wyatt

## DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

Executive Director.....2  
*Failure of a Model*

President's Page.....6  
*Accountability*

*Aquatic Hazard*.....8  
*Mycobacterium Marinum Infection*

LeRoy F. Harris, M.D.  
W. Howard Striplin, M.D.  
Richard C. Burnside, M.D.

Newly Licensed Doctors.....13

*How the Relative Value Scale*  
*Could Save Medicine* .....15  
Jane M. Orient, M.D.

*Refining the Designs of the Future*  
*American Health Care System*.....18  
Jacques R. Caldwell, M.D.

*Rabies, raccoons, and suburbs*.....22  
Pascal James Imperato, M.D.

Classifieds.....26

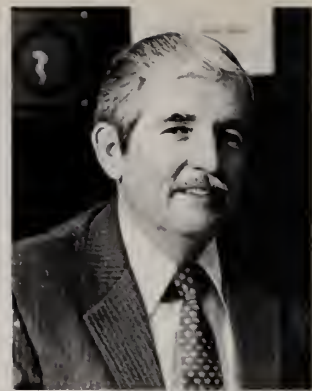
Auxiliary.....28  
*Anniston M.D. Takes E.R. Experience to South Korea*

*Things Aren't As Good As They Used To Be*.....29  
Richard L. Mabry, M.D.

*Our Sainly Legacy*.....30  
Stanley M. Aronson, M.D.

*When Electricity Was a Panacea*.....32





S. Lon Conner  
Executive Director, MASA

## Failure of a Model

All but lost in the cataclysmic events signaling the failure of world socialism was the historic vote in Sweden in mid-September: the Swedish people handed the long-governing Social Democrats their worst election defeat in 60 years.

Sweden, the world's most extensive welfare state, was long hailed by the more respectable, or less disreputable, socialists in this country as the paradigm of the ideal state. A noted Alabama author, in the years before World War II, paid tribute in a celebrated book entitled, *Sweden: Model for a World*.

On Sept. 15, the voters of Sweden gave the Social Democrats, the architects and the custodians of the country's suffocating welfare state, only 38% of the vote, their worst defeat since 1928.

Observers could not say what the Swedish people voted for, but no one was at a loss to explain what they voted against—a welfare state that, in the words of a *New York Times* correspondent, “costs too much and exerts too much influence over their lives.”

If the Swedes seemed to have little idea what they wanted in place of that dismal state, they were at least emphatic about saying it must go.

Last year, taxes equalled 57.7% of Sweden's gross national product, highest in the Western world. All five non-socialist parties in the election had vowed to cut taxes.

More importantly, perhaps, they all promised to roll back the public sector and heed Swedes' requests for more personal choice by opening up social services, principally health care, to more competition from the private sector. One of the five, formed just last February, promised much deeper tax cuts and to dismantle the welfare state brick by brick.

On the defensive, the Social Democrats unwisely portrayed themselves as the party that would defend the welfare state. Over the last six decades they had built what they called the third way between capitalism and communism. Its hallmarks were neutrality, free trade, centralized bargaining, a high level of cradle-to-grave benefits available to everyone, and high personal taxes.

For a time, that model for the world did not seem to impede Swedes from having one of the highest standards of living in the world, along with some powerful multinational corporations. But, as the *Times* report from Stockholm said, “the public sector grew increasingly bureaucratic and inefficient.” The results were predictable to any student of human nature — “high inflation, anemic economic growth, fleeing business investment and rampant worker turnover and absenteeism, which crippled companies and social services.”

The key to the public's disenchantment seems to have been mounting disaffection with socialized medicine: “Swedes have had to wait for years for cataract or other operations, and some have died awaiting heart bypass surgery.”

We have already learned of the health care disasters in the Soviet Union and the entire Eastern Bloc but Sweden was to have been the middle way that would make socialized medicine not only respectable but the envy of the world. Obviously, the judgment of the Swedish people was that it failed.

Even now, the much younger Canadian system is showing signs of the same design flaws — a Big Brother bureaucracy cannot deliver, over time, the kind of compassionate, dedicated care that individual

# Whose Retirement Plans? Not Yours - That's For Sure !

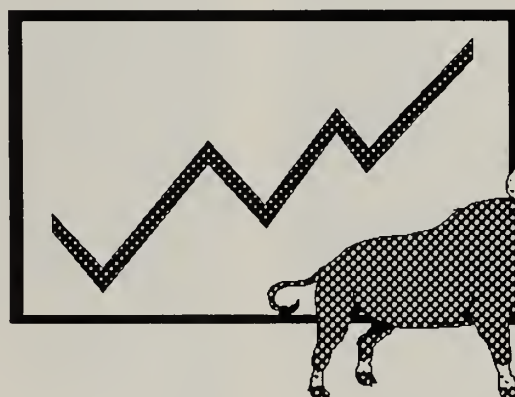
Think About All The Retirement Plan Costs You Pay. Lawyers - Trust Departments -



Stock Brokers - Accountants - Investment Advisors - Plan Administrators - ETC., ETC., ETC.

**Only Incredible Investment Returns Would Save Your Retirement Money From Being In a Perpetual Bear Market.**

**Would You Like To Convert To Retirement Plans**



**Which Grow Assets For You?**

Now, You have a Viable Alternative!

We offer retirement plan options ranging from investment management only, to that PLUS every service listed above — for an inexpensive % of your assets under our management! Our system will NET most physicians more profit on their retirement monies than ever before. And, if we don't obtain good results for you, our compensation suffers as well.

## INVESTMENT ADVISORY & MANAGEMENT CORPORATION

Suite 2110 First  
National Bank Building  
Mobile, Alabama 36602

1-800-239-1666  
In Mobile (432-1666)

References? Yes. We have the support of our existing physician clients — and they are very willing to discuss our services for them with you. For references or further information, such as a copy of our free retirement plan services pamphlet, please contact us.



**INVESTMENT ADVISORY & MANAGEMENT CORPORATION**



physicians can. Ultimately, any country and any bureaucracy that attempts to do that will fail because, sooner or later, cost, not care, becomes the determinant of who gets what.

Will the United States ignore these lessons of history? There are grim signs that in our fixes and proposed fixes we are determined to do just that.

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.

# YOCON®

## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in *Rauwolfia Serpentina* (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

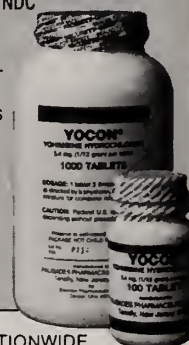
**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
  2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
  3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
  4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.
- Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES  
PHARMACEUTICALS, INC.**

219 County Road  
Tenafly, New Jersey 07670  
(201) 569-8502  
1-800-237-9083

**\$1,995\***

**Computerize your office for only \$1,995 and benefit from the speed and accuracy of electronic insurance claims processing and weekly cash funding.**

American Medical Finance has assembled the ideal combination of computer hardware, software and electronic claims processing. Thousands of physicians and other health care providers across the country are already benefitting from this easy-to-use, reliable and affordable system. Benefits to you include:

- Increased productivity and administrative staff efficiency
- Virtually error-free electronic insurance claims processing with no hook-up fee and instantaneous on-line claims editing
- Faster collection of all insurance claims and outstanding receivables
- State-of-the-art practice management tools
- Weekly Cash Funding services are available for fast, predictable cash flow

**For only \$1,995\*, you'll receive:**

- **Austin Computer's 286/16 Winstation.** Including 16MHz processor, 40 MB hard drive, CPU, keyboard, monitor, and 2400-baud modem, this computer has everything you need for practice management and electronic claims processing. Or for a total of only \$2,195 you may substitute the 386/16 Winstation. A frequent winner of PC Magazine Editor's Choice awards, Austin Computers are backed by toll-free technical support and on-site service by GE for one full year.
- **Easy-to-use Patient Accounting software PRELOADED onto your computer for immediate use.** Already in use in thousands of doctors' offices across the country, this comprehensive software package includes:
  - Accounts Receivable
  - Electronic Insurance Claims Billing
  - Practice Management
  - Patient Tracking
  - Management Reports
- **30-day money back guarantee.** AMF is the most easy-to-use, comprehensive, value-packed medical system in the marketplace. Your total satisfaction is guaranteed. Multiple user rates for lease or purchase are also available.



- **Access to AMF's electronic claims processing which includes instant on-line insurance claims editing, resulting in a 99% error-free rate.**

Widely regarded as the wave of the future in medical billing, electronic claims are often given priority payment scheduling over paper claims by many carriers as well as Medicare and Medicaid. As a result, claims that used to take three to four months for payment are often paid twice as fast.

- **Access to AMF's weekly cash funding services.** By providing advance cash funding of your insurance claims, AMF can give you a reliable, steady, weekly flow of cash to expand your practice, purchase additional equipment or simply enjoy the peace-of-mind of a predictable weekly cash flow.

**Entering the electronic age has never been easier or more affordable. Don't wait. Call today!**

\* Price of \$1,995 is based on a two-year electronic claims processing contract. Price without contract is \$2,995. Limited-time offer. This offer expires 12/31/91.



**AMERICAN MEDICAL FINANCE INC.**

**1-800-356-1511**

12801 N. Central Expwy., Suite 280 • Dallas, TX 75243







*William D. Lazenby, M.D.  
President, MASA*

## Accountability

Here is one of those words that has been around a long time but has been re-invented in this age as if to describe some revolutionary insight.

There has been much gnashing of teeth lately over the failed accountability of lawmakers in Washington, as if the voters have just discovered that politicians are supposed to serve the public that elected them.

Similarly, there has been much talk in recent years about teacher accountability — which simply means, stripped of all the verbiage, that anyone charged with the education of the young should be ready, willing and able. In short, they ought to be competent teachers.

There is nothing very novel in that demand except the necessity for the demand itself. The public is alarmed, with reason, over the declining quality of the education level of American youngsters. And when the public is alarmed it first looks for someone to blame. Teachers make a convenient target.

I suspect there may be something to the charge, but whether the appalling situation is wholly their fault or not, the only other people at the scene of the crime are the parents, who are now generating the demands for accountability.

There is overwhelming evidence that a major factor in the decline of public school education in this country is parental failure. For whatever reason, too many homes today do not provide the kind of environment necessary for the development of scholars.

It is revealing, I think, to note the progress of new immigrants from Asia in our schools. By and large they perform much better than the average child of native-born Americans. Why is this so? Experts say it

is almost entirely the result of parental expectations. Asiatic families value education highly, instill those values in their children and demand performance. Should it be so surprising that this works?

This digression is germane to my topic, I think, because it serves to illustrate how the public mind can be persuaded that if there is a word for it, then it's understood. The public seized on teacher accountability as the solution to the mess in public education. In other words, parents have simply identified a convenient excuse for their own failures ("Duty," Oscar Wilde once wrote, "is what one expects from others.")

Now we hear many of the same voices demanding accountability from physicians, when that has been the very first principle of the profession down through the ages.

Accountability, or the new fancy dress for it, is the rationale behind third-party review. Doctors, we are told in so many words, must be held accountable. The fact that we have been, through rigorous training, certification and constant peer oversight, seems to be ignored entirely, as if accountability were discovered in 1991 and not, as we all thought, back in the days of Hippocrates.

But that said, we are accountable, as we have always been. But we are accountable to our patients first and last. While we are well paid for what we do, what we do is quite a lot. Some managed-care reviewers seem to take the attitude, anathema to doctors, that good medicine must yield to economic conditions.

That's accounting; not accountability. It makes the dollar the determinant of care, not the patient's needs.

Even so, we are on our mettle: if we fail to practice efficiently, no matter how skilled the service, we will be called to the carpet by some distant clerk sitting before a computer loaded with protocols and algorithms that provide instant wisdom. Our accountability to our patients must, in such encounters, remain our non-negotiable standard.

But accountability also implies our acceptance of our own fallibility. Medicine, we are fond of saying, is not an exact science. This being so, the good physician keeps his mind open to alternatives, so long as these place the same highest priority on the patient's well-being, not the well-being of the insurance fund.

Above all, then, accountability means we are the

patient's advocate, his or her champion, forsaking all others. It does not mean that we have sealed our minds and will stubbornly refuse to change even when inwardly persuaded that an alternative is better.

Such intransigence is not accountability but its opposite, inflexible dogmatism born of false pride. It was Blaise Pascal, I think, who said the only constant in life is change. The mature mind, while resisting fad and novelty, will embrace all useful change, which is the way of all human progress.

In sum, the good doctor is accountable to his patient, to himself and to his profession, somewhat in that order. Following this simple catechism, he should never fall into serious error.

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

**P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992**

Above rates are provided by Jackson National Life



# Aquatic Hazard

## Mycobacterium Marinum Infection

LeRoy F. Harris, M.D.\*  
W. Howard Striplin, M.D.†  
Richard C. Burnside, M.D.\*\*

### Abstract

We describe two patients with Mycobacterium marinum infection and review the pertinent literature. M. marinum infection follows trauma, often trivial, in water or from marine life. Clinical manifestations include superficial cutaneous lesions which are either solitary or multiple in a sporotrichoid distribution, involvement of the deeper structures of the hand and wrist and disseminated disease. Biopsy of infected tissue reveals a mixed suppurative-granulomatous reaction with sparse to absent acid-fast bacilli. Definitive diagnosis is achieved by growing the organism from appropriate specimens. Suggested therapeutic regimens consist of rifampin and ethambutol for advanced disease and infection invading the deeper structures of the hand and wrist and one of the tetracyclines or trimethoprim-sulfamethoxazole for early or minimal disease. Surgical debridement is advised when there is persistent pain, a discharging sinus or previous local injection of corticosteroids.

Water serves as an essential part of our diet and a continual source of recreation but also can transmit many infections. Waterborne disease outbreaks have been caused by campylobacter, salmonella, shigella, giardia, hepatitis A, non-A, non-B hepatitis, norwalk agent and rotavirus.<sup>1,2</sup> Other infections acquired through contact with water include pseudomonas, vibrio, aeromonas, plesiomonas, legionella, leptospirosis, schistosoma, acanthamoeba and naegleria.<sup>3</sup> Mycobacterium marinum, another agent implicated in water associated disease, frequently is mistaken for other infections or diagnosed late in its

course despite suggestive clinical findings. We report two cases of M. marinum infection and review the pertinent literature to acquaint physicians with this aquatic hazard.

### Case Report

Case 1. A 42-year-old man was evaluated for a three month history of nodular swelling of the dorsum of the right hand. The patient maintained a home aquarium but denied trauma to the right hand. One month after the onset of illness the patient received a corticosteroid injection in the hand which resulted in increased swelling and extension proximally to the ulnar aspect of the forearm. A tuberculin skin test was reactive and an x-ray of the right hand disclosed soft tissue swelling without bony erosion. The patient underwent debridement and partial synovectomy of the hand and wrist. Histologic examination of the surgical specimen revealed mixed suppurative and granulomatous inflammation with numerous acid-fast bacilli which on culture grew *M. marinum* sensitive to ethambutol and cycloserine (no growth) and moderately sensitive to rifampin and streptomycin (1+ growth). The patient was treated with rifampin, 600 mg/d, and ethambutol, 1200 mg/d, for four months with gradual improvement.

Case 2. A 62-year-old female presented with a two month history of multiple red nodules which started on the ring finger of the left hand and spread proximally to the forearm (Figure). The patient kept a home aquarium which she cleaned without wearing gloves. A tuberculin skin test was reactive. Aspiration of one of the nodules disclosed a thick yellow material in which acid-fast bacilli were detected and from which *M. marinum* was grown. In vitro testing demonstrated sensitivity of the organism to rifampin and ethambutol. The patient received rifampin, 600 mg/d, and ethambutol, 1000 mg/d, for six months with slow resolution of the lesions.

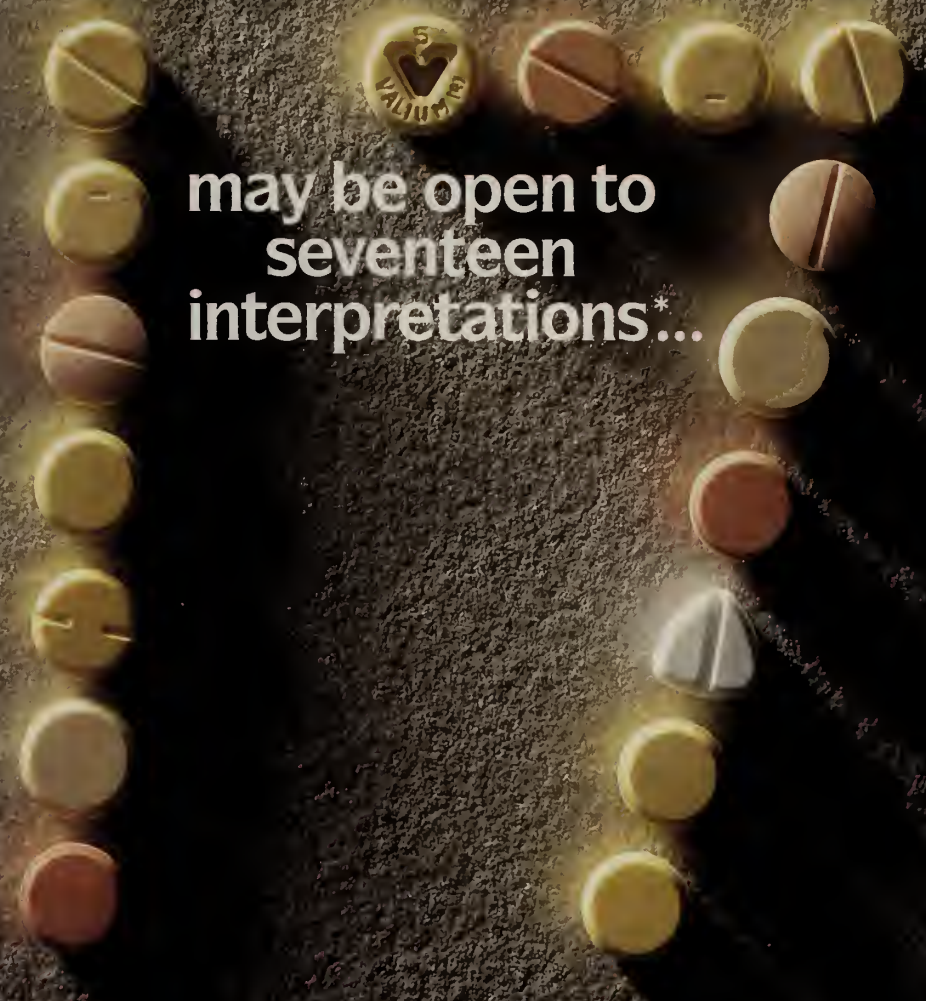
\*Clinical Associate Professor of Medicine, School of Primary Medical Care, University of Alabama School of Medicine at Huntsville, Suite A, 101 Bob Wallace, Huntsville, Alabama 35801.

†2227 Drake Avenue, S.W., Huntsville, Alabama 35801.

\*\*903 Madison Street, Huntsville, Alabama 35801.



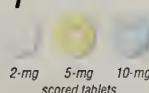
**Your Rx for  
Valium**  
(brand of diazepam/Roche)



**may be open to  
seventeen  
interpretations...**

**unless you settle the issue by signing  
on the "Dispense as Written" line.**

**VALIUM**<sup>®</sup>  
brand of  
**diazepam/Roche** <sup>®</sup>



2-mg 5-mg 10-mg  
scored tablets

*The final choice should really be yours*

The cut out "V" design is a registered trademark of Roche Products Inc.  
Copyright © 1991 by Roche Products Inc. All rights reserved.

**ROCHE** **Roche Products**  
Roche Products Inc.  
Manati, Puerto Rico 00701

\*According to the Orange Book, 10th ed, US Department of Health  
and Human Services, 1990, diazepam tablets may be available from as many  
as 17 companies. Tablets shown represent 5 mg diazepam tablets.





Multiple red nodules of the hand and forearm in a sporotrichoid pattern.

## Discussion

*M. marinum* is an atypical mycobacterium classified in Runyon group I, the photochromogens. It grows best at approximately 32° C and produces in 10-14 days cream-colored colonies in the dark which become bright orange on exposure to light. The organism inhabits fresh and salt-water as well as many marine animals. Infection in humans follows an incubation period of 2-8 weeks and is a consequence of trauma, often trivial, in swimming pools, aquariums and natural bodies of water or from fish and crustaceans.<sup>4,5</sup> Both of our patients developed infection from exposure to an aquarium.

Clinical manifestations of disease due to *M. marinum* appear as one of three patterns. Most commonly superficial cutaneous lesions begin as small papules which enlarge, suppurate and finally ulcerate. The lesions may be solitary or multiple in a sporotrichoid distribution along the course of lymphatic vessels. The extremities are most frequently involved.<sup>4,5</sup> A second clinical presentation is that of invasion of the deeper structures of the hand and wrist, including tendon sheaths and periarticular tissue, which appears as painless or mildly painful swelling and stiffness.<sup>6</sup> Lastly disseminated disease has been reported in a renal transplant patient.<sup>7</sup> One of our patients displayed multiple cutaneous nodules resembling sporotrichosis while involvement of the deeper structures of the hand and wrist was encountered in our other patient.

The diagnosis of *M. marinum* infection often is delayed and should be considered in any patient with cutaneous lesions or tenosynovitis following contact with water or marine life. Biopsy of infected tissue reveals a mixed suppurative-granulomatous reaction with sparse to absent acid-fast bacilli as detected by Kinyoun's tissue acid-fast stain and the auramine-rhodamine fluorescent stain. Definitive diagnosis is achieved by growing organisms from appropriate specimens. *M. marinum* infection with concomitant

satellite lesions most commonly is misdiagnosed as sporotrichosis. Other differential diagnoses consist of leishmaniasis, deep mycosis, cellulitis, tularemia, cutaneous tuberculosis, gout and rheumatoid arthritis. The standard purified protein derivative skin test infrequently is reactive.<sup>8</sup> Our patients were unusual in that acid-fast bacilli easily were visualized from involved tissue and the tuberculin skin tests were reactive.

Therapeutic recommendations for *M. marinum* infection are hindered by a lack of prospective studies and a paucity of cases encountered in any one medical center. Sensitivity studies of *M. marinum* reveal almost uniform susceptibility to rifampin and ethambutol, less activity of tetracyclines and trimethoprim-sulfamethoxazole and resistance to INH, para-aminosalicylic acid and streptomycin. Suggested regimens include rifampin and ethambutol for advanced disease and infection invading the deeper structures of the hand and wrist and one of the tetracyclines or trimethoprim-sulfamethoxazole for early or minimal disease. Duration of therapy ranges from a few months, to 4-6 weeks after clinical resolution and to 18 months.<sup>4,9</sup> Surgical debridement for infection involving the deeper structures of the hand and wrist is advised when there is persistent pain, a discharging sinus or previous local injection of corticosteroids.<sup>6</sup> Both of our patients received a prolonged course of rifampin and ethambutol and one underwent debridement and synovectomy.

## Bibliography

1. St. Louis ME. Water-borne disease outbreaks, 1985. MMWR 37 (Suppl S-2):15-23, 1988
2. Wanke CA, Guerrant RL. Viral hepatitis and gastroenteritis transmitted by shellfish and water. Infect Dis Clin N Am 1: 649-664, 1987
3. Pitlik S, Berger SA, Hummer D. Nonenteric infections acquired through contact with water. Rev Infect Dis 9:54-63, 1987
4. Sanders WE Jr, Horowitz EA. Other mycobacterium species. In: Mandell GL, Douglas RG Jr, Bennett JE, eds. Principles and practice of infectious disease. New York: Churchill Livingstone, 1914-1926, 1990
5. Prevost E, Walker EM Jr, Kreutner A Jr, Manos J. Mycobacterium marinum infections: diagnosis and treatment. South Med J 75: 1349-1352, 1982
6. Chow SP, Ip FK, Lau JHK, et al. Mycobacterium marinum infection of the hand and wrist. J Bone Joint Surg 69-A: 1161-1168, 1987
7. Gombert ME, Goldstein EJC, Corrado ML, Stein AJ, Butt KMH. Disseminated Mycobacterium marinum infection after renal transplantation. Ann Intern Med 94:486-487, 1981
8. Hummer D, Pitlik SD, Block C, Kaufman L, Amit S, Rosenfeld JB. Aquarium-borne Mycobacterium marinum skin infection. Report of a case and review of the literature. Arch Dermatol 122:698-703, 1986
9. Brown JW III, Sanders CV. Mycobacterium marinum infections. A problem of recognition, not therapy? Arch Intern Med 147:817-818, 1987

## Acknowledgement

The authors thank Juanita Spicer for preparation of the manuscript.

# AIM HIGH



## BE AN AIR FORCE PHYSICIAN.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. And enjoy the satisfaction of a general practice without the financial and management burden. Today's Air Force offers an exciting medical environment and a non-contributing retirement plan for physicians who qualify. Learn more about becoming an Air Force physician. Call

**USAF HEALTH  
PROFESSIONS  
TOLL FREE  
1-800-423-USAF**





# EIGHT GOOD REASONS TO SWITCH HEALTH INSURANCE COMPANIES

---

## 1 LOW RATES

*Compare our premiums to what you're paying now*

## 2 CHOICE OF DEDUCTIBLES WITHIN YOUR GROUP

*Mixing deductibles within your group can help control expenses*

## 3 PERSONAL SERVICE

*We're large enough to meet your needs - yet small enough to care*

## 4 A TRADITION OF TRUST

*We've been serving health care professionals exclusively since 1978*

## 5 AN A+ FOR FINANCIAL STRENGTH AND STABILITY

*Affiliated with Mutual Assurance, rated A+ by A.M. Best*

## 6 A CHOICE OF PROVIDERS

*Total freedom to choose the doctors you want to use*

## 7 RAPID CLAIMS HANDLING

*Most claims paid within two weeks*

## 8 NO PRE-CERTIFICATION REQUIRED

*No administrative headaches or hassles for you or your family*

IF YOU THINK THESE ARE GOOD REASONS  
CALL 1-800 344-9588

**LifeSouth**

PROFESSIONAL'S HEALTH PLAN

# Newly Licensed Doctors

Gebara, Simon A., M. D.  
P.O. Drawer B /Dept. Internal Medicine  
722 Stone Avenue  
Talladega, AL 35160

Allen, Bonnie Gayle, M. D.  
1323 Mulberry Street, Suite B  
Department Radiology  
Montgomery, A L 36 016

Collins, James Bernard, 111, M.D.  
1000 28th Place South, Apt. D  
Birmingham, AL 35205

Fortin, Robert F., M. D.  
3711 Birch Street  
Department Internal Medicine  
Ventura, CA 93003

Surapaneni, Purna Rao, M.D.  
333 Whitesport, #300  
Department Psychiatry  
Huntsville, AL 35801

Trent, Douglas Ernest,  
3140 Ivy Creek Road  
Department Ob-Gyn  
Gastonia, NC 28056

Wong, Lawrence Shawn, M. D.  
USAMC / Department Ophthalmology  
P. O . Box 8448  
Mobile, AL 36689

Malave, Ronald, M.D.  
700 Cottonwood Road/Dept. Psychiatry  
P.O. Box 6138  
Dothan, AL 36302

Coleman, Paul Houston, M. D.  
1650 Elm Hill Pike, Suite 4  
Department Anatomic Clinical Pathology  
Nashville, TN 37210

Mills, Allan David, M. D.  
Thomas Hospital/Department Emerg. Medicine  
US 98 at Morphy Avenue

Fairhope, AL 36532

Manyam, Vani, M.D.  
125 Pine Ridge Drive  
Department Anesthesiology  
Newark, NY 14513

Hannah, Gene Allen, M. D.  
American Sports Medicine Institute  
P. O . Box 550039  
Birmingham, AL 35255

Orosz, Louis David, M . D.  
1900 Clifford Street, #403  
Department General Medicine  
Ft . Myers, FL 33901

Ghidey, Yohannes, M.D.  
West Alabama Health Services, Inc .  
P.O. Box 711  
Eutaw, AL 35462

Michlin, John Paul, M.D.  
UAB / Emergency Medicine  
619 South 1 9th Street  
Birmingham, AL 35233

Evans, Helen Hughes, M. D.  
Children's Hospital of Alabama/Pediatrics  
1600 7th Avenue South  
Birmingham, AL 35233

Timken, Mark Jeffrey, M.D.  
833 South University Boulevard, #88  
Department Diagnostic Radiology  
Mobile, AL 36609

McFarland, Thomas Roy, M. D.  
10 1 Weems  
Department Family Practice  
Purvis, MS 39475

Mussell, Holly Green, M.D.  
818 College Avenue  
Department Pediatrics  
Birmingham, AL 35209



Poirier, Michael Patrick, M.D.  
Children's Hospital of Alabama/Pediatrics  
1600 7th Avenue South  
Birmingham, AL 35233

Buckley, Stephen Early, M. D.  
6700 Cottage Hill Road  
Department Internal Medicine  
Mobile, AL 36695

Bunch, Wilton H., M. D .  
Lakeshore Hospital/Orthopaedics  
3800 Ridgeway Drive  
Birmingham, AL 35209

Cartwright, Jefferson John, M.D.  
118 Fieldbrook Drive  
Enterprise, AL 36330

Chung, Clara Kyumee, M.D.  
The Children's Hospital/Pediatrics  
1600 7th Avenue South  
Birmingham, AL 35233

Engles, Robert Everet, M. D.  
1601 Summer Chase Drive  
Department Surgery  
Birmingham, AL 35244

Hassell, James Allen, M. D.  
Rush Hospital/Butler  
P.O. Box 518 - Hwy. 10 East  
Butler, AL 36904

LaGanke, Christopher Cole, M.D.  
UAB / Department Neurology  
UAB Station  
Birmingham, AL 35294

Lin, Selina, M. D.  
1755 15th Avenue South, #1  
Department Ob-Gyn  
Birmingham, AL 35205

Marlow, Robert Bruce, M.D.  
6731 SW Chaucer Drive  
Lawton, OK 73505  
After 11 /15/91:  
2915 Bob Wallace Avenue  
Department Family Practice  
Huntsville, AL 35805

McEvoy, Kevin Michael, M.D.  
11 Paradise Point Road  
Department Urology  
Shalimar, FL 32579

McFadden, David Larry, M.D.  
2425 Eraste Landry Road, Apt. 101-A  
Department Nephrology  
Lafayette, LA 70506

Mitchell, Jerry, III, D.O.  
P. O . Box 870138  
Department Emergency Medicine  
Mesquite, TX 75150

Plessala, Deneen Territo-Evans, M. D.  
Children's Hospital of Alabama/Pediatrics  
1600 7th Avenue South  
Birmingham, AL 35233

Rolfes, Steven Matthew, M.D.  
14699 Perdido Key Drive, #8-1  
Pensacola, FL 32507

Small, Suzanne Corrington, M.D.  
P. O. Box 7963  
Department Internal Medicine  
Mobile, AL 36670

Thanel, Fredric Harold, M. D.  
UAB/Department Family Practice  
930 Twentieth Street South  
Birmingham, AL 35294

Uchida, Derek Akio, M. D.  
USAMC / Department Pediatrics  
1504 Springhill Avenue  
Mobile, AL 36640

Yancey, William Burbridge, M. D.  
401 Lowell Drive, Suite 8  
Occupational/Emergency Medicine  
Huntsville, AL 35801

Al-Mubarak, Nadim A., M. D.  
UAB / Housestaff Office  
UAB Station - THT 229  
Birmingham, AL 35294

# How The Relative Value Scale Could Save Medicine

Jane M. Orient, M.D.\*

Pete Stark is absolutely right. The relative value scale (published in the June 5 *Federal Register*) is one way to "make sure that the nation's doctors have reason not to trust the government and have reason to resist any expansion of national health care."

Doctors may react to these fee screens the way a frog reacts to being thrown into a pot of boiling water. The frog might jump out and escape. Stark would prefer to put the frog into tepid water and turn up the heat gradually. That way, the frog is sure to be cooked.

Many physicians' organizations don't seem to mind being in the soup, as long as the fire isn't turned up too high. The relative value scale and fee limits are all right with them, in principle. They have only a few minor complaints. (1) The one-size-fits-all conversion factor is 16% too low. (2) Government research doesn't validate the concept of the "behavioral offset." (3) The conversion factor shouldn't be changed to "correct for transition asymmetry."

If Pete Stark and his cohorts have any sense, they'll let the doctors win on every one of these points. Then the doctors will be so busy congratulating themselves on their stunning victory that they might not have time to notice a few other problems: (1) the method itself, (2) the data used in the calculations, (3) the inability to correct wrong answers, (4) the behavioral adjustments that inevitably occur in response to price controls.

The method involves placing all physicians on a very short bed of Procrustes. It assumes that all doctors are exactly the same, regardless of specialty—and that a physician is the same as a "limited license practitioner" such as a chiropractor if they both do something that has the same code. It assumes that all patients are exactly average. It assumes that all doctors pay the same rent and can get the same discount for

supplies, regardless of the location or size of their practice.

The government did collect some data. For example, William Hsaio at Harvard surveyed doctors and tabulated their subjective impressions about the "work" involved in certain types of procedures, including milligrams of intellectual and psychological sweat. The researchers assigned an objective-appearing number to these guesses and processed them through a computer, making them even more objective (or at least further removed from their human origin). If Hsaio didn't come up with any actual survey results for a certain procedure, it didn't make any difference. The Health Care Financing Administration (HCFA) used "extrapolated data." (They made something up.)

For data related to practice costs, HCFA didn't even extrapolate. They just substituted whatever was at hand. For example, they used apartment rents as a proxy for commercial rents, even though the latter are much higher and have to include extra amenities like parking space. Or they simply made assumptions: "We have no reason to believe prices paid by physicians are any higher than pharmacies pay" (an average discount of discount of 15.9% off the published wholesale price).

From a purely mathematical standpoint, every single one of HCFA's fees is erroneous because they are all averages and nobody is exactly average. Because many of the numbers are "based on lack of data" (to quote one of HCFA's own expressions)—or on data that are at best outdated—the errors are likely to be very large. But there are no workable mechanisms for correcting error—only draconian punishments for doctors who charge a fee that is higher than the one dictated by the schedule.

In a free market, prices change from minute to minute as circumstances vary. If prices are frozen, something else has to give. To some extent, physicians whose services are "undervalued" have been able to compensate. Most impor-

---

\*Executive Director, Association of American Physicians & Surgeons



For excellent response in the treatment of  
duodenal ulcers...

# **AXID**<sup>®</sup> nizatidine has the right answers

- Rapid epigastric pain relief<sup>1,2\*</sup>
- Fast and effective ulcer healing<sup>2,3,4</sup>



**AXID**  
**PASSES THE ACID TEST**

\*Most patients experience pain relief with the first dose.  
See adjacent page for references and brief summary  
of prescribing information.

## AXID® (nizatidine capsules)

**Brief Summary:** Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. Active duodenal ulcer—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. Maintenance therapy—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlorazepate, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 300 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Fetal Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and decreased fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established. Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,500 nizatidine patients and over 1,300 on placebo, sweating (11% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported. **Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.


PV 2091 AMP  
[091190]

## References

1. Data on file, Lilly Research Laboratories.
2. Scand J Gastroenterol. 1987;22(suppl 136):61-70.
3. Scand J Gastroenterol. 1987;22(suppl 136):47-55.
4. Am J Gastroenterol. 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request

 **Eli Lilly and Company**  
Indianapolis, Indiana  
46285

tantly, they could collect part of the difference from the patient (up to the "MAAC"). Also, they could charge for giving injections or reading EKGs, or they could mark up the price of supplies or laboratory tests. No more. HCFA has tightened the limits on balance billing and has "included" extra charges in the average office visit, whether or not the physician receiving the money ever performed the service. (For example, dermatologists get a share of the EKG-reading fee.)

HCFA is correct: behavioral adjustments will occur. But the government is able to imagine only one type of adjustment. HCFA expects physicians to work harder and perform more services, even if they are already working 80 hours per week and can't find any more patients to see. This is not the only possibility. What inevitably happens under price controls is that quality deteriorates and shortages appear.

What can physicians do when their offices start to lose money? Choices include cutting back on services, firing staff, delaying the purchase of new equipment, or perhaps closing a practice altogether. If physicians are human beings, they will spend more time doing work that pays better, and less time doing work that pays poorly, not the reverse.

Pete Stark may want to hurt doctors. But the ones to suffer most from "physician payment reform" will be patients, especially patients with multiple, complex, time-consuming problems.

As Pete Stark fears, the relative value scale has revealed the true nature of the "partnership" physicians can expect with government. Begging Congress to turn down the heat a little this year is not the answer. The answer is to get the government's hands off the controls. Doctors need to jump out of the pot while they still can.

The government has the right to cut the Medicare budget and to determine Medicare reimbursements. But it has no right to dictate the value of a physician's services. Only physicians and patients can set a just value for the fee, by mutual consent.

There is one fair, effective mechanism for correcting errors in the government-fixed price: balance billing. Not incidentally, this is the only method that doesn't require coercion. Physicians' organizations should forget about manipulating the conversion factor. There is one and only one change that can help physician payment reform, and that one is absolutely essential: repeal restrictions on balance billing.

If the atrocity published in the June 5 *Federal Register* awakens physicians to this need, medicine will be deeply indebted to its author.



# Refining the Designs of the Future American Health Care System

Jacques R. Caldwell, M.D.

Editor, *Journal of the Florida Medical Association*

Political support for reconstructing the American medical care process is exponentially escalating. The demands are not mere pious bellowings emanating from behind the flaccid, lipid-laden jowls of a few leftover Sixties liberals. Rather, recognition of the need for change is slashed across the entire tapestry of society. Thirty-one to 37 million Americans may be uninsured at any time; others are under-insured. Insurance coverage is tyrannically and arbitrarily denied to many persons afflicted with chronic disease.

The 1991 Florida legislature nearly succeeded in imposing a socialized scheme of medical care. That attempt to inflict state control of fees and payments to health care—givers will be reintroduced in the 1992 legislature.

National political leaders within Congress and the executive branch are issuing near-daily proclamations about the need to redesign our health care system. A year ago the American Medical Association introduced its version of health care renovation—Health Access America. Support for revision is so widespread that some type of alteration is inevitable.

The structure of the future health care system is ambiguous; its contours hazy. The result could be grand or grotesque. Reformers display a naive penchant for the simplistic. They expect economic and social problems to be definable by tidy and predictable formulations such as  $E = MC^2$ . Unfortunately this expectation is not reflected by reality. Rather, social and economic systems are nonlinear. John Allen Paulos tells us in *Ruminations of a Numbers Man* that the elements in nonlinear relationships are not linked in a proportional fashion; thus doubling the magnitude of one part will not double that of another nor will the output be proportional to the input. Thus tiny alterations in one part of a system can produce prodigious and unpredictable changes in another part.

Cincturing one component of the medical care system may unbuckle and unleash socially disastrous consequences in another.

The governmental dalliances with the health care system during the past decade as exemplified by fee freezes, MAACs, DRGs, PROs, and postpayment utilization review confirm that social tinkering often generates unforeseen sequelae: health care costs have tripled and the number of the medically disenfranchised has doubled. This experience attests to the futility of a centrally-managed, health care reform movement. The medical care system is (to use a trendy expression) mathematically chaotic. This fact alone should discourage further, radical, centrally controlled reform. Furthermore, evaluating the outcomes of each limited modification should be done before introducing each incremental change.

Health care problems are highly regional and the needs of different populations can vary among neighborhoods. Certainly the problems in Hialeah differ from those in the rural Panhandle. Local leaders should be permitted to address their own peculiar requirements.

Health care experimentation on the local level must be encouraged. Alachua County has introduced the "We Care Program" to provide access to indigents who need all types of medical care from general medical to the sophisticatedly specialized. Palm Beach County, through its public health department, has funded and provides care for all its citizens. Tampa General Hospital has fostered the Genesis Program in which indigent pregnant women are recruited into the prenatal care program. The thesis of the hospital administrators is that they will be responsible for the pregnant women and babies no matter what the outcome. By marketing and encouraging the program they can prevent some of the disastrous fetal compli-



*You mean this is what I've been training for all my life?*



He trains year-round on the weights and on the track. But it wasn't long ago when he thought the race was over.

A diving injury had left Sammy Shute a quadriplegic. That's tragic news for anyone, but especially someone like Sammy who's been an athlete all his life.

With a whole new set of issues to come to grips with in his life,

Sammy found the strength he needed in the therapy at MMRC.

"I looked at therapy as competition," he said. "To do something better than I'd done it before. I guess you could say I was in competition with myself."

Over time, the staff helped him realize that by giving 110 percent every day, there was a multitude of things a person could do in a wheelchair. Like racing, for example. He went on to become

an inspiration not only to others, but to the very people who'd been such an inspiration to him.

It's that one-on-one relationship between patients and staff that makes MMRC the South's leading rehabilitation center. If you don't believe it, come out to the races one day. You'll see the proud results from start to finish.



**MMRC**

MISSISSIPPI METHODIST  
REHABILITATION CENTER

1350 East Woodrow Wilson, Jackson, MS 39216  
(601) 981-2611 or 1-800-223-6672



cations that will ultimately cost many more dollars than the Genesis Program. The unique medical care profiles of each community suggest that the future medical care system should be decentralized. This concept deserves further exploration.

Any new health system should foster experimentation into methods that will increase the productivity of the highly skilled health care providers such as doctors and nurses. Doctors and nurses armed with tools to provide care more efficiently will permit them to give the same, or more care, with fewer numbers of professionals. Obviously, limiting their paperwork responsibilities is the first step toward increasing productivity.

Explosion in the number of new doctors entering the health care system has been invoked as a major cause of medical cost inflation. Should we curtail training and transfer monies to research programs in medical schools? Most people will howl at this proposal but studies suggest that this may be economically beneficial.

The focus in any new medical care program will be fiscal and attempts will be made to further strangle reimbursements paid to hospitals and doctors. Yet hospitals are already providing care to government sponsored patients at rates that fail to cover costs. Physician net income from Medicare, Medicaid and other government sponsored programs is less than 4% of payments. If government truly wants to compress growth in medical care expenses it will have to look elsewhere. The combined costs of defensive medicine and regulation consume over 50% of the health care dollar. These are areas in which major savings could be effected.

Government credo dictates that layers of bureaucracy, like coats of smudged paint, will provide a proper cosmetic effect that will temporarily satisfy the constituencies to which it must genuflect. Yet the burdensome government regulations of the past decade have accelerated rather than retarded growth in health care cost. Administration expenses now consume

nearly 28% of the health care dollar and remain the fastest growing component of the health care budget. Deflating this cost by 50% would provide the resources to care for all the medically under-insured and uninsured in our society. Despite historical economic lessons that government price controls and excessive supervision always spawn waste and greater expense, government at every level still seeks to impose more administrative restrictions on the delivery of health care.

No government in the developed world, except Japan, has successfully suppressed health care costs. Except for Japan, all have enforced price controls. All have rates of health care inflation lower than ours; this may reflect that no nation outside the USA has so severely tethered its providers with such heavy regulatory manacles and none has the offensive legal system that encourages so much wasteful use of services in order to prevent lawsuits. Alleviating the American medical system from the excesses of its administrative and defensive medicine expense burden would reduce per capita cost of providing health care to a level less than that of Canada, Sweden, Germany and France.

If government representatives wish to design an economically streamlined and scientifically responsive American health care system for the 21st century, let us direct their activities toward targets that will be most productive—on appropriate administrative and tort reforms. If they insist on being involved, let them support research into systems of providing more efficient care and let them reassess medicine's personnel needs. Let them relinquish their insistence upon the establishment of a centrally controlled mechanism and divert their attention to providing incentives for local initiatives responsive to local needs. Most importantly, except for research and public health support, let us encourage them to remove themselves from the health care process. The record of American government programs in containing health care costs and enhancing access to the system is deplorable.

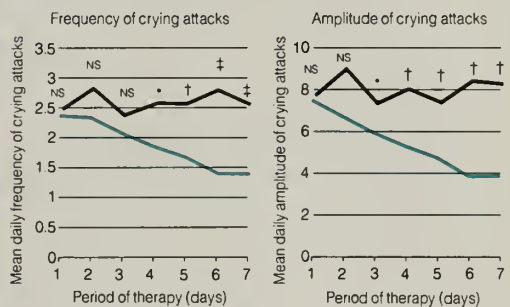
# Family therapy for colic.

The excessive crying of colic puts a strain on the most loving family—and often on their physician as well. And whatever the cause of colic, one fact is clear:

## Gas is often part of the colic problem.

New Phazyme Drops contains simethicone, which can safely break up gas and bring baby relief. That's why it can help whenever colic is a problem.

## Significantly reduces crying of colicky infants.<sup>1</sup>



Double-blind, randomized, placebo-controlled study

## Priced 25% below the leading brand.

This significant price advantage will be particularly important to parents, since they may be relying on Phazyme Drops for up to three months. And it's naturally flavored—something else they'll appreciate.



# Phazyme Drops<sup>®</sup>

(simethicone/  
antigas)

## Helps you through the colic phase.

1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508.

REED & CARNICK  
Piscataway, NJ 08855

©1989 Reed & Carnick

PZ24



# Rabies, raccoons, and suburbs

*Pascal James Imperato, M.D.  
Editor, New York State Journal of Medicine\**

Rabies has long been enzootic in wildlife populations in the southeastern United States where raccoons have played a major role in its transmission.<sup>1</sup> Although a wildlife rabies epizootic began to move north in the early 1970s, it was the translocation of raccoons from enzootic areas in the southeastern United States that is linked to the epizootic that began in the mid-Atlantic region in 1977 and which has since spread into New York State and Connecticut.

Infected raccoons were translocated north to supplement local populations hunted for sport. The numbers of these raccoons translocated by hunting clubs was substantial, totaling 2,300 alone in 15 eastern counties of Kentucky in 1975-1976.<sup>2</sup> Smith et al detected the first rabid raccoon in the epizootic in West Virginia in 1984. After their report, raccoon rabies was documented in Virginia, the District of Columbia, Maryland, and Pennsylvania. The rapid spread of this epizootic among raccoons is illustrated by the fact that Maryland, which had no known rabid raccoons prior to 1981, reported 735 in 1983.<sup>3</sup> As of December 1987, 95 rabid raccoons had been reported within the city limits of Baltimore.<sup>4</sup>

In early May 1990, a rabid raccoon was shot by police in the daytime on the grounds of the Addison Central School in Steuben County, New York. Two months later a second rabid raccoon was identified in the same county. At that time, five rabid raccoons were found in Sullivan County. The first human exposure in New York State occurred on July 8, 1990, when a six-year old girl was attacked in the town of Delaware by a rabid raccoon. In April 1991, a rabid raccoon tenaciously chased a cyclist in Ridgefield, Connecticut.<sup>5</sup> The large population of suburban raccoons coupled with the course of the current epizootic

are predictive that rabies will appear in a number of suburbs in the next few years.

Contrary to what many assume, farmland and wilderness areas support lower densities of raccoons than suburban landscapes.<sup>6</sup> Suburban and periurban areas provide abundant food sources in the form of garbage, and sewers and other isolated spots are excellent shelters. Not surprisingly, the spread of suburban developments into what was once farmland has frequently resulted in the natural introduction of raccoons into areas where they were once unknown. A case in point familiar to this writer is southwestern Queens county, which until the early 1950s contained considerable farmland. Herman L. Brockmann, whose family farmed 50 acres along Cedar Lane between 1862 and 1953, does not recall that raccoons were ever present in this part of the county (personal communication, 1991). Yet, raccoons gradually moved into this area in the 1970s after it had become heavily suburbanized.

Terrestrial rabies has been absent in indigenous animals in New York City and many of its suburbs for several decades. Although dog bites are a serious problem in the city and surrounding areas, in recent decades there has been little concern about rabies.<sup>7</sup> Although rabies has been consistently found in bats, human exposure is minimal. The spread of rabies in raccoons and other wildlife populations increases the risk of transmission to nonimmune domestic animals, especially dogs and cats, and through them to humans. Given these facts, both the New York City and New York State Departments of Health have strongly recommended the routine vaccination of both dogs and cats as have professional veterinary associations. In some jurisdictions, such as Westchester County, the vaccination of dogs and cats has been made mandatory.

Although the epizootic spread of rabies among raccoons is cause for concern, it should not lead to panic.

---

\*Professor and Chair, Department of Preventive Medicine and Community Health, State University of New York, Health Science Center at Brooklyn, Brooklyn, NY 11203.

# THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

## \$10,000 - \$20,000 - \$30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association

From the epidemiologic perspective, rabies epizootics in these animals run a limited course of a few years, finally ending because of mortality rates and human interventions that reduce populations.<sup>3,6</sup> In spite of this positive news, the disease can still linger and its rates increase as the raccoon population recovers over a period of time.

The primary prevention of rabies is fairly routine, but it consists of measures that many are apt to overlook. Although raccoons are primarily nocturnal, their interactions with domestic pets such as cats and dogs are fairly common. Thus, the regular vaccination of domestic pets not only protects them, but also prevents their transmitting the disease to humans. Transmission risks can also be reduced by not allowing pets to run loose, even in a closed yard, since raccoons can easily breach most enclosures. Domestic pets should not be taken to enzootic areas where transmission risks are high. If they are taken into such areas, they should not be allowed outdoors unless leashed and under visual supervision. While in enzootic areas, individuals should not acquire domestic pets, unless there is documentation of rabies vaccination.

The wisdom of this precaution was well illustrated by the case of a Manhattan couple who in 1990 brought back a stray kitten they found while vacationing in a rabies enzootic area in Pennsylvania. The kitten developed rabies, and some 10 individuals exposed to it then had to undergo post-exposure prophylaxis.<sup>8</sup> Under no circumstances should individuals or their domestic pets have physical contact with wild animals, alive or dead, either at home or while away. In this regard, parents should make special efforts to warn children not to touch wild animals they may encounter. Rabies may render raccoons and other animals lethargic and easy to approach, thus increasing the risk of transmission. The day time appearance of usually nocturnal animals such as raccoons should raise suspicions that they may be rabid, and children should be informed never to approach them. Keeping wild animals as pets poses special risks since rabies vaccines are often ineffective in conferring immunity in some species.

The development of human diploid cell vaccines, a rabies vaccine adsorbed from rhesus lung diploid cell

culture and human rabies immune globulin (HRIG) has greatly facilitated the postexposure management of patients.<sup>9</sup> Postexposure prophylaxis is determined by a number of variables including the risk of rabies exposure in a given area, the type of exposure, the immunization status of the animal if known, and the results of an examination of the animal and/or its brain tissue. In determining an appropriate management plan, physicians should consult with their local health departments, which can advise whether or not treatment is necessary, provide guidance on how it is to be carried out, arrange for the examination of animal brain tissue and assist in the close surveillance of domestic animals when available. In most instances both vaccine and HRIG must be administered as described in the special article in this issue of the *Journal*.<sup>10</sup>

As has been the case with a number of diseases, including tuberculosis and syphilis, rabies has reemerged as a public health concern. This re-emergence requires the implementation of some fairly simple preventive measures long deemed unnecessary during the many-decades-long rabies-free era. The adoption of these measures coupled with the appropriate management of those exposed should prevent human deaths from rabies and minimize the anxiety and fear now present in many communities where rabid raccoons have been found.

## References

1. Kappus KD, Bigler WJ, McLean RG, et al: The raccoon as an emerging rabies host. *J Wildlife Dis* 1970; 6:507-509.
2. Nettles VF, Shaddock JH, Sikes RK, et al: Rabies in translocated raccoons. *Am JPublicHealth* 1979; 69:601-602.
3. Jenkins SR, Winkler WG: Descriptive epidemiology from an epizootic of raccoon rabies in the middle Atlantic states, 1982-1983. *Am J Epidemiology* 1987; 126:429-437.
4. Laboratory confirmed rabies cases in Maryland, 1985-1987. Baltimore, Maryland Department of Health and Mental Health, 1987.
5. Glaberson W: A tide of anxiety over rabies sweeps the New York region. *NY Times* May 6, 1991, B1 B7.
6. Anthony JA, Childs JE, Glass GE, et al: Land use applications and changes in population indices of urban raccoons during a rabies epizootic. *J Wildlife Du* 1990; 26:170-179.
7. Harris D, Imperato PJ, Oken B: Dog bites. An unrecognized epidemic. *BuaNYAcadMed* 1974; 50:981-1000.
8. Rabies: City Health Information, 1990; 9(5):1-3.
9. Rabies Prevention—United States, 1991. Recommendation of the Immunization Practices Advisory Committee (ACIP), *MMWR* 1991; 40 (RR-3):1-19.
10. Rabies Prevention in the United States, 1991. Recommendation of the Immunization Practices Advisory Committee, *NYState JMed* 1991; 91:342-346.



# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

FPs and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

ALABAMA—Enjoy a centralized deep South location with cosmopolitan convenience and southern charm. Our 100-physician multi-specialty group in Birmingham has immediate opportunity for Board Certified diagnostic radiologist with training/experience in MRI, CT and Special Procedures. Large referral base and exclu-

sive coverage of 600-plus bed medical center with Level Three trauma service. Highly competitive compensation, liberal benefits including professional liability, and opportunity for full partnership. Send C.V., or direct inquiries, to Bill Mylius, Norwood Clinic, P.O. Box 830230, Birmingham, AL 35283, (205) 250-8903 collect.

ER PHYSICIANS NEEDED for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

FP, IM, GS, GP needed in rural South AL flourishing practice. Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

PSYCHIATRY—Unique and immediate ground-level opportunity for two (2) aggressive and energetic BC/BE Psychiatrists. Established office practice with large referral base offers general psychiatry, geriatrics, substance abuse programs, family, marital and group therapy, and we will develop additional programs. Highly competitive compensation, liberal benefits including professional liability, and opportunity for full partnership. Send C.V., or direct inquiries, to Bill Mylius, Norwood Clinic, P.O. Box 830230, Birmingham, AL, 35283 (205)250-8903.

ORTHOPEDIC SURGERY—Two (2) positions available immediately for BC/BE Orthopedic Surgeons at a major multispecialty clinic in Birmingham. Active general office practice (primarily adult) with a broad referral base and exclusive coverage of 600-plus bed medical center. Highly competitive compensation, liberal benefits including professional liability, and opportunity for full partnership. Send C.V., or direct inquiries, to Bill Mylius, Norwood Clinic, P.O. Box 830230, Birmingham, AL 35283 (205)250-8903.

## Term Life for Less... Much Less

They said compare, so we did.

Review these low male, non-smoker annual rates and call for quotes.

<u>AGE</u>	<u>\$250,000</u>	<u>\$500,000</u>	<u>\$1,000,000</u>
25	175*	275	500
30	175*	275	500
35	190*	305	560
40	210	340	630
45	235	385	720
50	373	635	1,220
55	525	975	1,900
60	838	1,625	3,200

All coverage is provided by companies rated A by A.M. Best Co. (Female rates lower)


Call (205) 279-8756 for quotes

H. Ben Coker III, CLU, ChFC  
Specialist in Life, Health & Disability

2835 Zelda Rd #7 Montgomery, AL 36106

\*200 minimum premium required by First International Life Insurance company

# LEXINGTON CLINIC: PRESCRIPTION FOR SUCCESS



**J**oin a dynamic, fast-growing, multi-specialty group practice located in the rapidly expanding Bluegrass region. We are seeking motivated physicians to become part of our health care team.

Founded by Mayo Clinic trained physicians in 1920, Lexington Clinic continues to be a respected leader in health care. We are a major business organization with an aggressive growth program.

If you're interested in making a difference, explore this outstanding career opportunity. Consider joining our innovative health care resource center serving Central and Eastern Kentucky, as well as Ohio, Tennessee, and West Virginia.

Lexington Clinic is located in Lexington, the heart of the picturesque Bluegrass region of Kentucky. Long established as a major employer in the region, Lexington Clinic is expanding services to continue providing exemplary health care to patients.

Come join our team of 110 physicians in 27 specialties and be a part of the vital role that multi-specialty clinics will be playing in the future of health care.

To foster professional growth and fulfill your goals, call 1-800-523-7592 to learn more about Lexington Clinic. Materials will be sent confidentially.

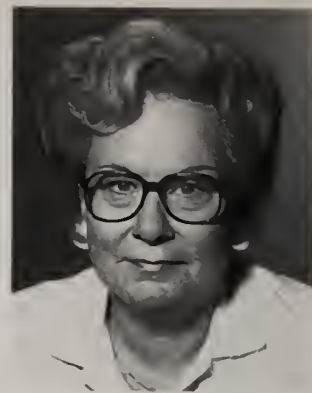
**Specialty areas targeted for recruitment include:**

**Allergy  
Cardiology  
Dermatology  
Family Practice  
Gastroenterology  
Hematology/Oncology  
Infectious Diseases  
Internal Medicine  
Neurology  
Neurosurgery  
Obstetrics/Gynecology  
Occupational Medicine  
Ophthalmology  
Orthopaedics  
Otolaryngology  
Pathology  
Pediatrics  
Physiatry  
Pulmonary  
Rheumatology  
Surgery - General  
Surgery - Plastic  
Urology**



**Lexington Clinic, P.S.C.  
1221 South Broadway  
Lexington, KY 40504  
1-800-523-7592**





*Mrs. Stuart K. Bean  
A-MASA, President*

## Anniston M.D. Takes E.R. Experience to South Korea

**D**r. and Mrs. Howard McVeigh are pretty much a typical medical family in Alabama, which means sometimes they do exceptional things to serve their fellow man. One chance came a few years ago when Dr. McVeigh was invited to go to South Korea as a medical advisor. Dr. McVeigh is the director of the emergency department of Anniston's Northeast Alabama Regional Medical Center.

They have two children, Brian who is married and attends Birmingham Southern College, and Heather who is in eighth grade.

It was through friends at their church, Drs. Howard and Marilyn Kitchens, that McVeigh learned his expertise in emergency medicine was just what was needed at Wallace Memorial Hospital, a large, busy facility in Pusan, South Korea. The Kitchens, a urologist and pediatrician who are from Anniston, were serving as medical missionaries in Pusan. When help was needed to plan expansion at their hospital and evaluate the emergency department they called on McVeigh.

Several weeks later McVeigh took the 20 hour flight to Seoul and began his adventure. He found Seoul to be a "clean and efficient metropolis." Pusan, a southern port city on the coast of the Sea of Japan, was large and populated but had more of the look and feel of a blue collar working center.

Pusan is a city of five million people in a land area about the size of Calhoun County. That is the equivalent of the entire population of the state of Alabama crammed into one of its counties. It was a

busy place with construction everywhere. And everywhere was the odor of kim-chee pots,

McVeigh's time was quickly focused on the Wallace Memorial Hospital. This Southern Baptist Convention hospital is a teaching facility with surgery, medicine, OB-gyn, pediatric and sub-specialty faculty and residents. While McVeigh believes the care at the hospital is comparable to an American teaching hospital he found the emergency department was 20-25 years behind the times.

One of the biggest problems McVeigh encountered was the poor access to the emergency room itself. There was no separate emergency room entrance. Patients had to enter through the back door of the hospital, which was also a delivery truck unloading zone.

Transport to the ER was not done by ambulance. "The majority of patients, including multiple-trauma victims, arrived by taxi and were carried into the hospital in the arms of bystanders or family," he said. Ambulances were used to transport patients between hospitals or home, not as emergency vehicles. And there was no emergency medical service as we know it in the U.S. to care for patients en route to the hospital.

This hospital's emergency room really was a room — a long, widened corridor approximately 15 by 40 feet. Stretchers were placed side by side and end to end. Duty in the E.R. was the least desirable duty and assigned to the most junior staff in the surgery department. The residents working there might be the equal of a junior in an American medical school.

Following Dr. McVeigh's recommendations the

Korean hospital administrators hired a faculty level physician "to work in, oversee, and teach in the emergency department." Emergency was elevated to a department in its own right instead of being the stepchild of other departments. An ambitious building and remodeling project was already underway to correct some of the hospital's physical limitations.

Considering the traffic in Pusan, Dr. McVeigh found an efficient emergency room very important in this city where motor vehicle accidents are a major source of morbidity and the fatality rate is 11 or 12 times what it is in the U. S. "They have a somewhat fatalistic view," Dr. McVeigh continues. "They believe, for instance, that if a person is hit by a car fate has intervened and it was 'meant to be'." He often observed six lanes of traffic where four should be. And those six lanes could balloon to seven or eight lanes at intersections or wider areas of the road. The direction lanes of traffic would go depended on force of numbers and how many cars were going in which direction. Traffic signals were ignored, according to Dr. McVeigh, who says, "I asked why they even have stop signs and lights and was told 'if you need to stop, that would be where you should stop'."

In visiting outlying areas Dr. McVeigh saw several Buddhist temples, including the oldest one in Korea. He drove through the countryside where the land was rocky and had frozen rice paddies cut into the steep mountain sides. In the sun, he says, they gave the appearance of a fragmented mirror. He saw homes that were no more than 10 by 10 feet with masonry walls and floor. According to Dr. McVeigh, "They were heated by maintaining a fire beneath the floor thereby heating the floor and the whole house. The room served as living room, kitchen, and at night mats were rolled over the warm floor as beds. There was essentially no furniture."

Some of Dr. McVeigh's most memorable experiences were with various missionary families. Said Dr. McVeigh, "While getting ready for work and school, during meals, and at family devotions, these families lived their faith. They behaved as a large, extended family even to the point of calling others aunt and uncle."

Dr. McVeigh is a deacon of Golden Springs Baptist Church where he and Marilyn are active members. "I had such mixed emotions as he left," Marilyn recalls, "but thankfully we have AT&T!" Marilyn says now that she is sorry that their children's activities kept the whole family from going to South Korea. But she adds, "Hopefully we'll all go on the next trip."

**Donna Specker**

## Things Aren't As Good As They Used To Be... And Probably Never Were

*Editorial, Southern Medical Journal*

Yesterday I heard the results of a survey that caught my attention. More than 60% of the respondents in the study said that their work was no longer enjoyable, though at one time it had I been. The primary reasons given were cutthroat I competition, outside interference and bureaucracy, and lack of appreciation for a job well done. What caught my attention about it? The respondents weren't physicians; they were middle managers in major US corporations.

I guess the lesson in all this is that although we as physicians may complain bitterly (and I undoubtedly complain as loudly as anyone else) about those exact same problems, we are not alone in our troubles. The times, indeed they are a'changin'. The pace is faster, everyone (it seems) wants to tell us what to do and how to do it, and technology is advancing almost more rapidly than we can assimilate the changes and learn how to use them.

Having spent almost a quarter of a century in private solo practice, I can look back to the times when I seemed to be in control of my practice (instead of 40 jillion insurance companies and review organizations, not to mention the government), when patients were actually grateful for my efforts, and when I felt a sense of accomplishment in what I was doing. But as my wife sometimes reminds me, the good old days weren't always that good. Time has a way of mercifully glossing over the rough spots, and leaving us yearning for good old days that were not unalloyed pleasures.

For example, I complain about the difficulties of learning such new techniques as endoscopic sinus surgery (grumbling frequently about old dogs and new tricks), but not a day goes by that I don't bless this new fiberoptic technology. Just today I was able to take care of a tricky bit of sinus surgery that 20 years ago would have been a nightmare for me (and the patient). Instead, she left the hospital a few hours after surgery, asking if I really had operated because she "didn't feel that bad." And for the rest of the day, I managed a smile and didn't complain once about how bad the modern practice of medicine has gotten.

Maybe the man was right. Today is the yesterday you'll yearn for tomorrow.

Richard L. Mabry, MD  
3450 W Wheatland Rd Suite 260  
Dallas, TX 75237



# Our Saintly Legacy

*Stanley M. Aronson, M.D.  
Rhode Island Medical Journal*

While many Western healers and physicians have been venerated during the past three millennia remarkably few have entered the ranks of formal sainthood. Indeed, records indicate that only 40 of the many thousands achieving canonic sainthood have actually been physicians.

The pre-eminent saintly physician is Luke the evangelist, companion of St. Paul, and, according to second century writings, a physician of Greek origin probably born in Antioch. The third of the four Gospels in the New Testament, a masterpiece of eloquent poetry, is ascribed to him. Scholars have reviewed this book of the New Testament; and while it contains greater descriptions of miraculous healing than do the other three Gospels (ie, Matthew, Mark and John) they nevertheless fail to identify any part of the text which corroborates the alleged medical background of its author.

Saints Cosmas and Damian, fourth century physicians, were martyred during the reign of Diocletian. The two brothers were born in the Middle East, studied medicine in Syria and because they practiced their art without charging a fee they were known widely as the Anargyroi (ie, without silver). The brothers would not reject their faith and were accordingly crucified. It is said that arrows were then shot at them but rebounded upon the executioners. A century later the Emperor Justinian underwent a miraculous cure and dedicated a church in their honor, in Constantinople. The many murals, paintings and sculptures of the sainted physician-brothers depict them as youthful, attired in long robes and red hats and carrying the emblems of their trade—mortars, medicine cases, and urine glasses. Five English churches (in Kent, Sussex, Wiltshire and Herefordshire) are dedicated to their memory and their relics are found in Canterbury Cathedral and

numerous other churches in Europe and the Middle East. The two, inseparable in history, also became the patron saints of numerous cities including Florence, Essen, Prague and Salamanca.

St Pantaleon, said to be born in Venice about the year 305, is yet another patron saint of medicine. He too was martyred during the years when Diocletian ruled Rome. His name survives in the narrow trousers originating in Venice, now called pantaloons.

There are other saints, not themselves physicians, whose names became eponymic of certain diseases because they had been associated in some manner with events of miraculous healing. Yet others were known as patrons of the medical profession.

The mode of martyrdom frequently determined the patronymic domain of each saint. Thus, for example, Apollonia received many blows to her jaw during her final torment and later became the patron saint of dentistry. St. Erasmus had his intestines torn from him and thus became the saint to be venerated when one was seized with abdominal colic.

The personal illnesses of the saints became yet another point of reference for those seeking their divine intervention. Thus, SS. John, Lupus, Thomas and Avertin were said to have epilepsy and they have thus become the patron saints of all movement disorders. The name of St. Avertin, a 12th century hermit from Tours, persists today as the secular trade-name of the basal anesthetic, tribromoethanol. St. Giles, an 8th century Athenian hermit, was said to be lame and thus was later chosen as patron of the crippled. His benevolent intervention was repeatedly recorded and over 160 English churches bear his name.

There are a moderate number of eponyms in medicine carrying the names of saints. These include:

St. Agatha's disease: mastitis  
St. Anthony's fire: ergotism

St. Dymphna's disorder: psychoses

St. Fiachra's disease: hemorrhoids

St. Gotthard's disease: hookworm (When the tunnels for the transalpine railroads were dug, near St. Gotthard's Pass, numerous workers developed ankylostomiasis. Modern epidemiologists ascribe the endemicity to the widespread fecal contamination of the tunnel floors and the subsequent penetration of the larval worm through the bare feet of the workers.)

St. Louis Encephalitis: (Named after the city, not the saint.)

St. Martin's evil: delirium tremens. (Probably because St. Martin's feast day coincides with the pre-Christian feast of Bacchus.)

St. Main's disease: scabies. (The herb, teasel or scabiosa, is said to cure the disorder; in Europe, the plant is called l'herbe de St. Main.)

St. Roche's plague: (St. Roche was a profoundly pious Frenchman, born during the end of the 13th century. He devoted his life to the care of the ill, particularly during the pestilence of the 13th century including the great bubonic plague beginning 1347. He is said to have developed a bubo on his left thigh

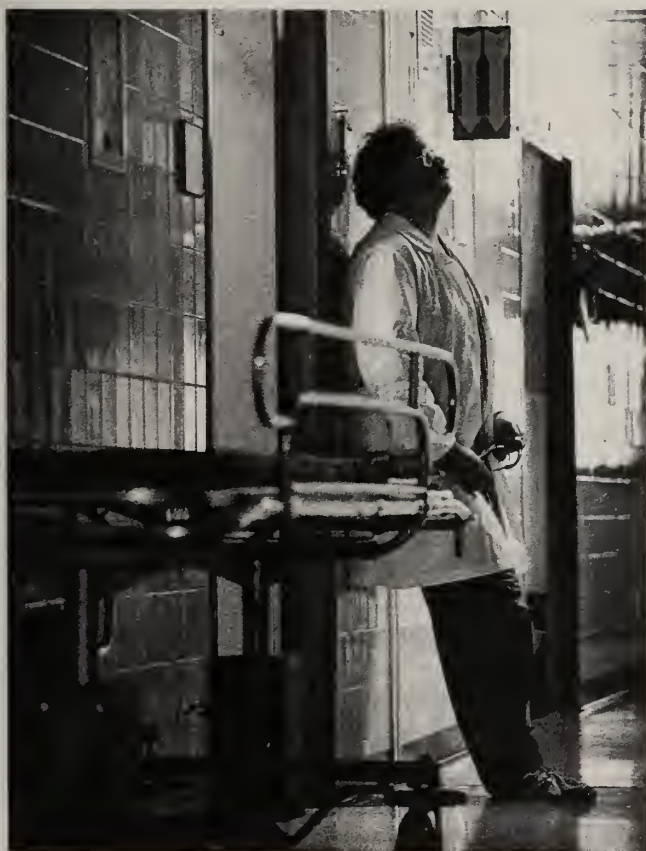
and numerous paintings depict this ulcer.)

St. Valentine's disease: epilepsy.

St. Vitus' dance: a form of rheumatic chorea. (Vitus, a 4th century Sicilian, would not renounce his Christian faith and was ultimately beheaded. During the dancing mania epidemics eleven centuries later, those who undertook pilgrimage to the shrine of St. Vitus in southern Germany were said to be cured of their involuntary movements and, through transference, the name St. Vitus affixed itself to the disease.)

Sanfilippo's syndrome: mucopolysaccharidosis (Named not after the saint but after the physician who first described this inborn error of metabolism in 1963.)

The historic records of most of these canonized men and women are incomplete. But it is unlikely that any of these pious souls could have envisioned that their names would have been immortalized principally by virtue of an association with some dreary human ailment. Someone observed that the ultimate test of fame is to have a crazy person imagine that he is you. To this, we may add the perpetuation of some names solely by their attachment to a dreaded disease.



"Being a patient advocate is what being a physician is all about."

Dr. Kevin Fullin, Cardiologist, Kenosha, Wisconsin,  
Member, American Medical Association

Why would a cardiologist get involved in the issue of family violence? Perhaps, because what he saw simply cried out for action.

"Fully a third of all women's injuries coming into our emergency rooms are no accident," says Dr. Fullin.

While others were content to downplay the issue of family violence, Dr. Fullin would not. He petitioned state officials, and through his efforts the first Domestic Violence Advocate Program in his state was created.

"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

The American Medical Association (AMA) couldn't agree more. We're committed to focusing physician attention on the issue of family violence.

Become a member of the AMA today.

Members of the AMA are encouraged to join their state, county and specialty societies.

American Medical Association

Physicians dedicated to the health of America





# When Electricity Was a Panacea

## *Indiana Medicine*

During the 19th century, physicians had few effective remedies to offer to their patients. By the Civil War, most doctors had abandoned the traditional remedies of bloodletting and purging. Except for a variety of tonics, a doctor was left with few treatments for disease.

The public was not satisfied with this therapeutic void and turned to nostrum vendors and medical device manufacturers to relieve their many ailments. These entrepreneurs took advantage of the public's unrelenting quest for cures and provided them with a plethora of worthless and even dangerous over-the-counter remedies and medical gadgets touted to cure everything from the common cold to cancer. Electricity was one recurring fad in medical therapeutics.

America's fascination with electricity and medicine dates to the late 1700s. Electrical tropical fish were used in Charleston, S.C., to treat palsied patients. Benjamin Franklin, who brought electricity down from the sky in the 1750s, helped a doctor use electricity in treating a woman with convulsions.

The first quackery device introduced in America was Elisha Perkins' metallic tractors. Perkins believed that when these two small metallic rods were rubbed over the surface of the skin they would draw off "noxious electrical fluids." Many people, from the common man to physicians and lawyers, extolled the virtues of these devices. Perkins' tractors unlocked the imagination of the American public—perhaps electricity held the key to health.

After the Civil War, interest in medical electricity soared as scientists began exploring the mysteries of electricity. Many believed that the human body was

electrical or magnetic in nature. By the late 19th century, many doctors even asserted that the loss of balance of electricity within the body was responsible for disease. The brain furnished electricity to the rest of the body; the nerves carried the electro-nervous fluids or electricity. Books such as *The Electric Physician* (1875) and *A Manual For Magnetizing* (1845) became popular.

The interest in electricity spurred many manufacturers to develop medical electrical kits or magneto-electric machines that provided a mild electric current designed to cure almost every disease known to mankind. These devices consisted of a small wet or galvanic cell that when activated (by turning a crank) would give the patient a mild electric current. The Indiana Medical History Museum has a wide variety of electrical gadgetry used to cure disease. A recent addition to the collection is the Davis and Kidder Magneto-Electric Machine, patented in 1854. The device was used to cure "nervous diseases."

Professor Benjamin Silliman, a noted geologist, wrote about the device: "For neatness, compactness and facility and energy of operation, it is far superior to any instrument of the kind which I have seen. For medical application, it possesses very decided advantages."

Other electrical devices flooded the market, including electric socks, electric hairbrushes and combs, electric necklaces and electric extracts and fluids. The fascination with medical electricity continued well into the 20th century. The 1938 Food, Drug and Cosmetic Act limited the claims that manufacturers of medical devices could make, which in turn, limited the production of medical quackery devices.



# SYSTEMS CORPORATION

Independent Medical Systems Consultants

---

*At SYSTEMS CORPORATION, we believe that computer systems should do what you pay them to do. Quietly, unobtrusively, and profitably.*

*We believe appropriate selection of software, correct installation, informative training and open-ended availability of our assistance, coupled with your commitment, will result in a successful system.*

*Yes, we are in business to make money — by making you money through well considered recommendations of software and hardware for your medical practice. As consultants, we are at liberty to recommend the very best choices to you — the payor of our fee. We can assist you with your present system or assemble a new well-rounded computer system based on evidence pertinent to your practice.*

*And guess what? We will obtain for you wholesale — or near wholesale — prices for every product we recommend.*

*What should you expect from your practice management system?*

- *Comprehensiveness — before buying, be sure that a system has been well designed, well tested, and is in widespread use throughout the United States. Proprietary (home-grown) systems are simply unacceptable.*
- *Controls — so you can know that your practice's revenue system is working for you and that it requires your employees to do the same. This can mean real money in your pocket.*
- *Electronic Billing — so you can expedite your practice's cash flow and reduce billing costs.*
- *Expandability — so it is unlikely that you'll ever outgrow your system's capabilities.*
- *Customization — so that you can add special features you desire, such as medical histories accessible by you when you are not in your office.*

*As highly trained specialists, we will earn your trust — and our keep. Next time you have these kinds of things in mind — no matter the size of your need — won't you see what we can do for you?*



SYSTEMS CORPORATION  
1-800-239-1717  
Suite 2108, First National Bank Building  
Mobile, Alabama 36602  
(In Mobile, call 432-1313)





The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia, HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6143V

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

A91CA6148T

When diet and exercise alone are not enough...



ONCE DAILY 180mg Calan SR Iverapamil HCl 180mg SUSTAINED-RELEASE CAPLETS

MILD START IN MILD HYPERTENSION

© 1991, G.D. Searle & Co.

November 1991

Vol. 61, No. 5

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

JAN 13 1992

*Do The Right Thing*  
Dr. Lazenby, pg. 6

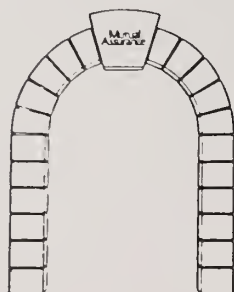


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 5, NOVEMBER 1991

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.  
POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1991 by the Medical Association  
of the State of Alabama

EDITOR  
Claude L. Brown, Jr., M.D., Mobile  
ASSISTANT EDITOR  
Wm. H. McDonald, Montgomery  
ADVERTISING & DESIGN  
Rhonda Myers, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Joel C. Pittard, M.D. (1992); Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown)  
1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Polmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large  
\*\*Member, Board of Censors  
\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## • STAFF •

EXECUTIVE DIRECTOR  
S. Lon Conner  
Secretary-Treasurer - Emmett Wyatt  
DEPARTMENTS  
Legal - Wendell R. Morgan  
Education - George D. Oetting  
Governmental Affairs - Richard C. Whitaker  
Public Relations - Holley Midgley  
Communications - Wm. H. McDonald

## In This Issue

Executive Director.....2  
*Friendly Fire*

President's Page.....6  
*Do The Right Thing*

*Contemporary Results of Carotid Endarterectomy*.....10  
James V. Richardson, M.D., F.A.C.S.

Newly Licensed Doctors.....14

*When Providing State-Of-The-Art Medical Care  
Is Not Enough* .....19  
Bill Weaver, Ph.D.

*The Health Care 'Industry'*.....24  
K.L. Shaffer, M.D., F.A.A.P.

*Survey Underscores Changing Attitudes of  
Young Physicians* .....26  
Phil Miller

*Just Send the Bill to Blue Car and Blue Truck*.....28  
Alieta Eck, M.D.

Auxiliary.....30  
*Dr. and Mrs. Richard Shepard*

Classifieds.....32





*S. Lon Conner  
Executive Director, MASA*

## Friendly Fire

Recently, one of Washington's better known political think tanks issued a report on American health care containing a statement that would not have been shocking had it come from the lips of Teddy Kennedy but was definitely unsettling considering the actual source:

"Today's basic system evolved not in response to the needs of consumers, but according to the marketing and professional objectives of suppliers of health care."

If that had been nothing more than the usual blather of some anti-doctor liberal group, I would not have given it a second thought. It got my attention solely because of the source —the Heritage Foundation, certainly the most conservative of the ilk and one with which, I suspect, 95% of American physicians would agree 95% of the time.

It is this kind of friendly fire that has contributed most to the anxiety of the American physician, who fears that the almost universal outrage over the high cost of health care will encourage politicians to throw the baby out with the bath. The danger is doubly real because Congress is itself under heavy fire from a public convinced that Washington is out of control; that the Congressmen we elect no longer care about much of anything but insuring their own perpetuity in office; that they have lost touch with the needs of the people with whom they no longer identify, etc., etc.

Stung by this fairly universal contempt, Congress may be expected to answer extremes with extremes. Because the cost and availability of health care are very close to the top of the list of public anxieties — along with rising crime and declining standards in

education, it is a time fraught with danger for physicians.

All the more so, in my opinion, because conservative comment is no longer very different from liberal bleats. That probably began with the health care work of the U.S. Chamber of Commerce and the alarms sounded by the automobile industry, a chorus led by former HHS Secretary Joseph Califano at Chrysler and trumpeted by others whose refrain became this: America is losing its industrial competitive edge in world markets because the high cost of health care adds so much to the cost of every car, washing machine, and computer.

This oversimplification is demagogic in the sense that business and industry know that the average American understands little, and cares less, about all the complex ingredients of pricing on world markets. This was a charge that was guaranteed to win instant acceptance, since few of our citizens are blind to the fact that modern health care is expensive.

When you don't have the foggiest notion of what technology costs; when you give no thought to the uncountrd billions added to our health bill by preventable disease rooted in reckless life styles; by the jungle warfare in the central cities; by the carnage on our highways; by the consequences of teenage pregnancy; and by our insatiable appetite for more and more of everything — when a mind is untroubled by any of these factors, naturally the doctor is the cause of it all. Who else?

Politicians of left and right now exploit this public ignorance rather systematically because they know they will not be held accountable for their attacks on



# SYSTEMS CORPORATION

Medical Systems Consultants

Suite 2108, First National Bank Building

Mobile, Alabama 36602

1-800-239-1717

(In Mobile, call 432-1313)

## Universal Electronic Billing !

- (1) Now your practice can electronically bill all third party payors — in care of one location.
- (2) Now you can put more money in your pocket, much faster!

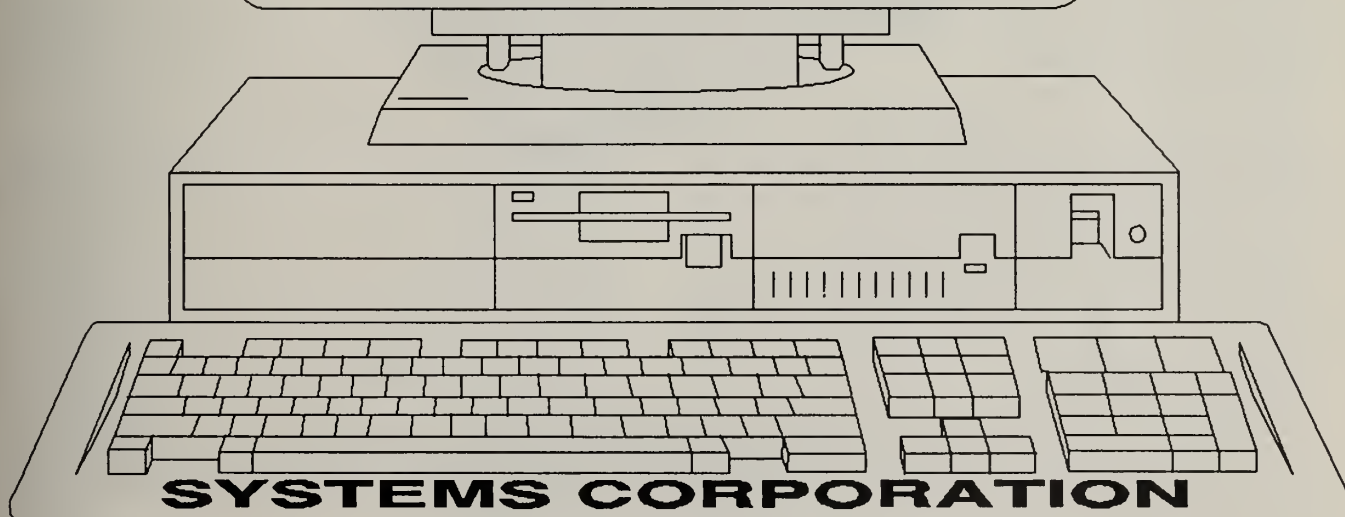
### Your Cost Today?

\$695 for the software — installed in your office — on your machines!

45¢ per Electronic Charge transmitted!

For Further Information, Please Call:

**1-800-239-1717**



### Comparisons

- I. In 1990, the administrative cost of processing a paper claim approximated \$3.50. Utilization of our Electronic Billing System can today reduce costs to \$1.50 per claim, approximately.
- II. Reimbursement from paper claims can take 7-8 weeks versus 2-3 weeks from Electronic Claims.



everybody's favorite economic scapegoat, the American healer.

Public and politician alike love their own doctors, of course; it's all those others causing the problem. Here in Alabama, for example, even as this is being written, doctors are being identified as the chief villains in the rising rates of worker compensation insurance.

For purposes of argument, all the cost increases are simply listed under "medical" without any attempt to define terms. Does that include rehab hospitals, home health care, durable medical equipment, chiropractors, podiatrists? They won't say.

It bothers me greatly than even conservative Alabama businessmen don't demand from the State Department of Industrial Relations a detailed cost analysis of where the money goes for injured workers. The man who would be czar of this program has refused, since early in the year, to provide such a detailed breakdown.

The obvious inference to be drawn is that such an analysis would hurt his lobbying effort to enact a law that would place the care of injured workers under utility-type regulation and empower him as a kind of one-man PSC.

Only in the present climate of doctor-bashing would such an outrageous idea be proposed. And only in such a climate would a surprising number of otherwise savvy businessmen buy it. All too many of their numbers nationally are ready to embrace, as a pig in a poke, the Canadian system, along with majority of American private citizens.

Somewhere in North America a television commercial is being aired, probably at this very moment, depicting emergency room doctors trying to save the life of a little girl. Frustrated by the lack of equipment, a nurse cries out, "We're losing her!"

The scene abruptly shifts to a health care bureaucrat with a bored look on his face. The 60-second spot ends with this voice-over: "Bureaucracy. It could become our worst disease."

You haven't seen that commercial because it is being run only by private TV stations in Canada. It is an attack by concerned Canadians on the system too many Americans think they want. Because it hits a nerve, the state-run Canadian Broadcasting System has banned the commercial from its programs. Government officials warn that the 20-year-old Canadian system is in danger of bankruptcy because of soaring costs.

And yet it is this bureaucracy so many of our conservative friends, joining the liberals, say would be

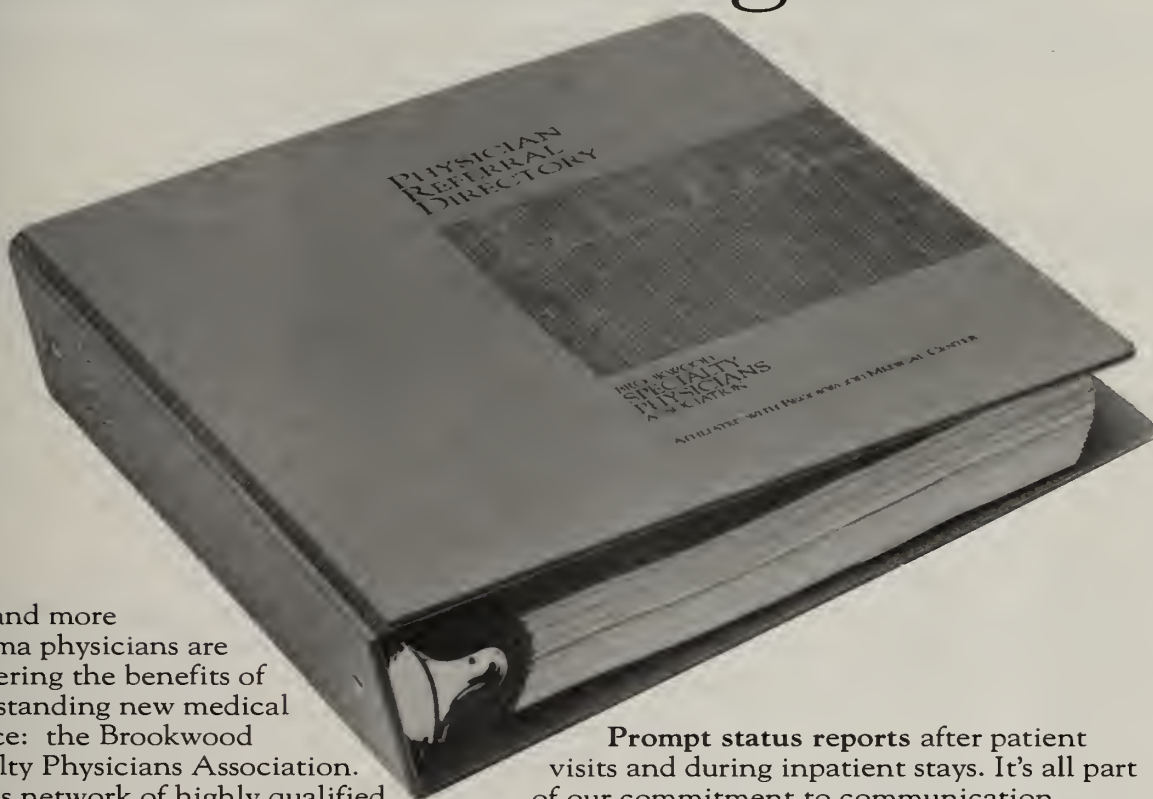
the salvation of American health care. For conservatives to favor bureaucratic control and regulatory overkill could tell us something about the reasons for our failure in world competition — too many of our captains of industry, spoiled by years of easy big bucks, are turning to federal and state bureaucracies to save them from those beastly foreigners —and doctors.

U.S. Postal Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION <small>Required by 39 U.S.C. 3685</small>			
1A. Title of Publication <b>Alabama Medicine</b>		1B. PUBLICATION NO. 2 8 4 - 7 2 0	2. Date of Filing 9/27/91
3. Frequency of Issue monthly		3A. No. of Issues Published Annually 12	3B. Annual Subscription Price \$15 members \$30 non-members
4. Complete Mailing Address of Known Office of Publication (Street, City, County, State and ZIP+4 Code) (Do not precede with P.O. Box 1900, Montgomery, Alabama 36102-1900)			
5. Complete Mailing Address of the Headquarters or General Business Office of the Publisher (Not printer) P. O. Box 1900, Montgomery, Alabama 36102-1900			
6. Full Name and Complete Mailing Address of Publisher, Editor, and Managing Editor (This area MUST NOT be blank) Publisher (Name and Complete Mailing Address) Medical Association of the State of Alabama, 19 South Jackson St., Montgomery, Alabama 36104 Editor (Name and Complete Mailing Address) Claude L. Brown, M.D., P.O. Box 1900, Montgomery, AL 36102-1900 Managing Editor (Name and Complete Mailing Address) William H. McDonald, P.O. Box 1900, Montgomery, AL 36102-1900			
7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Form must be completed.)			
Full Name The Medical Association of the State of Alabama		Complete Mailing Address P.O. Box 1900 Montgomery, AL 36102-1900	
8. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities. (If there are none, so state)			
Full Name none		Complete Mailing Address	
9. For Completion by Nonprofit Organizations Authorized to Mail at Special Rates (DMM Section 431 (2) only) The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes (Check one) (1) <input checked="" type="checkbox"/> Has Not Changed During Preceding 12 Months (2) <input type="checkbox"/> Has Changed During Preceding 12 Months (If changed, publisher must submit explanation of change with this statement.)			
10. Extent and Nature of Circulation (See instructions on reverse side)		Average No. Copies Each Issue During Preceding 12 Months	
A. Total No. Copies (Net Press Run)		5,600	
B. Paid and/or Requested Circulation 1. Sales through dealers and carriers, street vendors and counter sales		5,400	
2. Mail Subscriptions (Paid and/or requested)		5,409	
C. Total Paid and/or Requested Circulation (Sum of 10B1 and 10B2)		5,409	
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies		70	
E. Total Distribution (Sum of C and D)		5,479	
F. Copies Not Distributed 1. Office use, left over, unaccounted, spoiled after printing		130	
2. Return from News Agents		118	
G. TOTAL (Sum of E, F1 and F2—should equal net press run shown in A)		5,600	
11. I certify that the statements made by me above are correct and complete		Signature and Title of Editor, Publisher, Business Manager, or Owner <i>William H. McDonald</i>	

PS Form 3526, Feb. 1989

(See instructions on reverse)

# Presenting The Medical Resource That More Alabama Doctors Are Referring To.



More and more Alabama physicians are discovering the benefits of an outstanding new medical resource: the Brookwood Specialty Physicians Association.

This network of highly qualified physicians represents virtually every medical specialty. But it's more than a group of doctors. It's a total system of convenient, comprehensive referral services:

**Physician Referral Directory**, a free, user-friendly guide to all our specialists.

**Toll-free referral line** for setting up referrals and making appointments.

**Prompt status reports** after patient visits and during inpatient stays. It's all part of our commitment to communication—ensuring that you, the referring physician, are an integral, informed part of the “care loop.”

For more information, or for your free Physician Referral Directory, call 1-800-292-4859 (877-1887 in Birmingham).

And see for yourself why more Alabama

doctors are referring to the physician network that wrote the book on referral services.

BROOKWOOD  
SPECIALTY  
PHYSICIANS  
ASSOCIATION

AFFILIATED WITH BROOKWOOD MEDICAL CENTER

THE PHYSICIAN NETWORK THAT SPECIALIZES  
IN CONVENIENT, COMPREHENSIVE REFERRAL SERVICES.





William D. Lazenby, M.D.  
President, MASA

## Do The Right Thing

*"All doctors really care about is money."*

While few patients will say this to their physician's face, this is said to be the most common public attitude toward physicians collectively. We have all heard this indirectly, and we may choose to shrug it off as just another benighted attitude about medicine from a public uninformed about medicine generally.

In my judgment, we do so at our peril. It has been known for a long time that Americans like their personal physician but distrust the profession at large in much the same way, and for many of the same reasons, that they will re-elect their own congressman but hold the mass of Congress in utter contempt, as a collection of nest-feathering opportunists with an eye on the fast buck.

Like Congress, which was once respected if not revered in the same way we were, we are perceived as forgetting our calling, our roots, indifferent to the public good, propelled only by our self-interest, and no longer driven by our dedication to service to society.

It is a cop-out on our part, I believe, to dismiss these attitudes as merely another example of the benighted public's ignorance about almost everything.

A few years back, an Alabama physician who had studied the malpractice crisis and its root causes as thoroughly as anyone, who had reflected on its genesis and metastasis, was asked in an interview to say, if he could, what was the single most important factor in the willingness of patients to sue and juries to award gargantuan verdicts.

The physician paused to reflect on the question, then said something like this:

"There are many contributing factors, of course, but chief among them, I am convinced, is the public perception of us as greedy. The perception of us as interested only in making money. The perception of us as no longer entitled to the respect we earned by the good works we once did out of a sense of duty, without pay. This perception, I believe, is the primary reason we no longer enjoy the benefit of the doubt; that we no longer enjoy the presumption of total integrity and absolute dedication."

Even after we strip away all the myths about modern medicine and the unfavorable comparison of it with the kindly, self-sacrificing doctor of the good old days; even when we take into account the necessary depersonalization attendant to the scientific revolution in medicine and the proliferation of specialized care that, by definition, distances doctor and patient, we are left with a nagging question: Is any of it true?

Have we, in fact, drifted from the selfless ideals of the profession to the extent that we are vulnerable to the charge that we are but other examples of the age of greed symbolized by the names of Boesky, Milken, et al? Have we been infected by even a trace of the same avarice that gave us the Wall Street scandals, the S&L and banking atrocities, and the other examples of the vaunted American free enterprise system running amok?

It is too facile to respond that even if this charge might have a grain of truth in it, so what?— we still provide the best health care in the world whether they love us or not, and whether we are driven by the almighty dollar or not.

It is also much too easy to blame it all on govern-

# Whose Retirement Plans? Not Yours - That's For Sure !

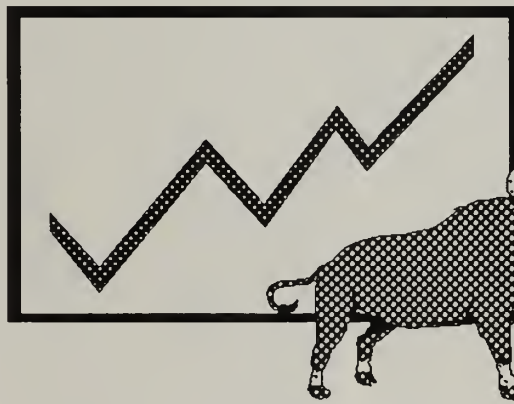
**Think About All The Retirement Plan Costs You Pay. Lawyers - Trust Departments -**



**Stock Brokers - Accountants - Investment Advisors - Plan Administrators - ETC., ETC., ETC.**

**Only Incredible Investment Returns Would Save Your Retirement Money From Being In a Perpetual Bear Market !**

**Would You Like To Convert To Retirement Plans**



**Which Grow Assets For You?**

We offer complete investment management on an individualized basis for every physician as well as complete retirement plan services which include every service listed above.

Our comprehensive system will net most physicians more profit on their retirement monies than other alternatives.

Our charge is an inexpensive % of your assets under our management.

## **INVESTMENT ADVISORY & MANAGEMENT CORPORATION**

Suite 2110 First  
National Bank Building  
Mobile, Alabama 36602

1-800-239-1666  
In Mobile (432-1666)



And, if we don't obtain good results for you, our compensation suffers.

References? Yes. We have the support of our existing physician clients — and they are very willing to discuss our services for them with you.

For references or further information, such as a copy of our free retirement plan services pamphlet, please contact us.

**Registered Investment Advisor**

**With the U.S. Securities Exchange Commission and The States of Alabama and Mississippi**



ment: that had not the politicians imposed Medicare and Medicaid on the nation, thus institutionalizing health care as a right, we would still be caring for patients gratis as a professional obligation. By this line of reasoning, we are still Teflon-coated and no charge can stick to us.

But the charges are sticking and we owe it to ourselves, to our predecessors and to those who will succeed us, to examine our souls. Do we provide enough free care to those who fall between the cracks? Do we, as individuals, give enough to other public charities to a degree commensurate with our high incomes in a state of relatively low incomes? Do we join our fellow citizens in efforts to improve our communities? Are we, in short, the good citizens we should be?

These are questions we should all ask ourselves. If you are less than satisfied with your self-inventory, move to make amends for your shortcomings as a member of the family of man. And this should be done not out of a foot-dragging, grudging sense of resignation only to appease popular attitudes and thus improve the "image" of the physician. We should do these things because they are right, because we owe society a heavy debt for the great opportunity for service that is ours, and because of the immemorial concept of noblesse oblige — much is expected of those

to whom much is given — the simple burden of our calling.

It is all too easy to point to the bean-counters in HCFA and elsewhere in the expanding environment of managed care as an excuse for selfishness. But that is all that it is — an excuse, an expedient rationalization that, in your heart of hearts, you know to be disingenuous.

Find ways to give more of your good fortune to your fellow man — increase significantly, and willingly, the fraction of free care you provide. Give more, much more, to worthy charities. Help some needy and deserving student through college or medical school. Get involved in community betterment programs.

Because it's good PR? No, because it is good for you and your own sense of worth as a privileged member of society willing to give back a small portion of what society has given you. Do it for yourself, for your profession, for your own personal contribution to advancing the human condition.

I think you will thus experience more deep and abiding self-esteem than can ever be gained from all the material acquisitions of abundance.

Life is short; we come this way but once. Let's make the most of it.



## "Being a patient advocate is what being a physician is all about."

Dr. Kevin Fullin, Cardiologist, Kenosha, Wisconsin,  
Member, American Medical Association

Why would a cardiologist get involved in the issue of family violence? Perhaps, because what he saw simply cried out for action.

"Fully a third of all women's injuries coming into our emergency rooms are no accident," says Dr. Fullin.

While others were content to downplay the issue of family violence, Dr. Fullin would not. He petitioned state officials, and through his efforts the first Domestic Violence Advocate Program in his state was created.

"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

The American Medical Association (AMA) couldn't agree more. We're committed to focusing physician attention on the issue of family violence.

Become a member of the AMA today.

Members of the AMA are encouraged to join their state, county and specialty societies.

American Medical Association

Physicians dedicated to the health of America





*"And I thought rehab was just a fancy name for Therapy."*



Dr. Karl Hatten doesn't work in rehabilitation, but he knows more about it than many so-called experts. He got his experience first-hand. As a nephrologist, he's spent more than 25 years helping patients deal with life-threatening diseases. But when he was hit by a stroke, he saw his own life hanging by a thread.

"Like many doctors, I had been

confused by all the physical therapy programs that refer to themselves as rehab," he says. "My experience at MMRC taught me there's a big difference.

"The staff was incredibly supportive. They set realistic goals for my recovery, and helped me regain my self-confidence." In six months as a patient Dr. Hatten learned more about rehab than in 25 years as a doctor. Now he under-

stands why MMRC is the South's leading rehabilitation center.

Today, he's back at work. With a fresh outlook on life. And a new perspective on rehabilitation.

Because when it's done right, rehab can do a lot more than repair a patient's body. It can even help a doctor see things more clearly.



**MMRC**

**MISSISSIPPI METHODIST  
REHABILITATION CENTER**

1350 East Woodrow Wilson, Jackson, MS 39216  
(601) 981-2611 or 1-800-223-6672



# Contemporary Results of Carotid Endarterectomy

*James V. Richardson, M.D., F.A.C.S.\**

## Summary

Forty-four patients underwent fifty carotid endarterectomies in the first eighteen months of a new solo practice of cardiovascular and thoracic surgery in Montgomery. Thirty-six of the patients (82%) were symptomatic. Important operative details including continuous EEG monitoring, "selective" shunting, "open" endarterectomy and complete heparinization were employed throughout the study. There were no deaths and no strokes. Two patients (4%) had transient cranial nerve palsy and one patient (2%) had a transient ischemic attack consisting of dysarthria. One patient (2%) had a wound hematoma requiring reoperation. These results, in light of recent medical trials and randomized medical and surgical studies, encourage the continued place of carotid endarterectomy in the treatment of significant carotid disease in both symptomatic and asymptomatic patients.

## Introduction

Despite several natural history studies<sup>1,2</sup> and randomized trials of medical and surgical therapy for carotid artery disease<sup>3,4</sup> the role of carotid endarterectomy in the treatment of patients with significant carotid artery disease remains controversial. For carotid endarterectomy to be beneficial, one must demonstrate lower operative mortality and stroke rates than would be observed in both symptomatic and asymptomatic patients undergoing medical treatment only. Callo<sup>5</sup> has reported that patients undergoing "optimal" medical therapy for carotid disease have a stroke rate of 2.9%-8% annually; the annual stroke rate following carotid endarterectomy in his experience was 1.9%. Gibbs<sup>6</sup> has illustrated that the mortality rate in large series of patients undergoing carotid endarterectomy can be as low as 0.5% and the

rate of permanent stroke as low as 1.6%. Additionally, Fisher<sup>7</sup> has reported an operative mortality rate of 1.1% for patients under the age of 70.

The results of this surgical series are reported to illustrate the current results of carotid endarterectomy which might be expected in community practice in Alabama.

## Methods and Materials

During the first eighteen months of a new solo practice, forty-four patients underwent a total of fifty carotid endarterectomies by an established cardiovascular and thoracic surgeon. Twenty-six patients (59%) were females and eighteen (41%) were males. Forty-one patients (93%) were caucasian and three patients (7%) were black. Ages range from fifty-two to eighty-three years. A total of thirty-six patients (82%) were symptomatic. These symptoms ranged from amaurosis fugax to a history of frank stroke with mild residual paresis. Other symptoms included transient ischemic attacks (TIA) and global symptoms from severe bilateral carotid disease.<sup>8</sup>

Carotid ultrasounds were performed in all patients and were performed in a number of institutions and interpreted by a variety of physicians. A total of twenty-two patients (50%) had additional arteriograms. In my experience, there has been an excellent correlation between carotid ultrasounds and arteriograms. No patients, who had high-grade disease diagnosed by ultrasound, were found to have an occluded carotid by arteriogram.

Surgical details, undoubtedly, greatly influence the results of carotid endarterectomy.<sup>8,9</sup> Continuous EEG monitoring<sup>10</sup> and the measurement of carotid "stump" pressure were employed in all patients. Therefore, a practice of "selective" shunting was employed and was necessary in only one patient (2%). Optical magnification with loupes and high intensity illumination were used. Full heparinization (7500 units-10,000 units) was employed in all patients. The heparin was generally not reversed, unless it was necessary for

---

\*Montgomery Cardiothoracic & Vascular Surgery, 303 South Ripley Street, Suite 1200, Montgomery, Alabama 36104.

control of wound hemorrhage. An "open" carotid endarterectomy was performed in all cases, regardless of the need to extend the arteriotomy well onto the internal carotid artery. Aggressive debridement of the intima was employed to reduce the risk of embolism and, presumably, post-operative thrombosis. Vigorous irrigation of the intima with heparin saline solution was used in eliminating atheromatous debris and showing additional intimal strands which needed to be removed prior to closing the artery. Microvascular closure was accomplished using 6-0 polypropylene suture. The sequence of vascular clamp removal is very important. The external carotid was unclamped first, internal carotid second and common carotid third with temporary occlusion of the internal carotid for several heart beats prior to establishing complete reperfusion. This allows atheromatous debris and any trapped air bubbles to go into the external carotid circulation rather than the internal carotid artery. Carotid cross-clamp time ranged from 11-33 minutes ( $\bar{m}$  15 mins.). After learning to drain these wounds with simple rubber drains during my residency and fellowship, I have evolved a practice of suction drainage of all carotid endarterectomy incisions.

Post-operative care was generally very simple. Maintenance of appropriate blood pressure with the use of intravenous nitroglycerin or nitroprusside was beneficial. Aspirin and dipyridamole are given in the recovery room and continued indefinitely. The wound drain as well as arterial line, IV and oxygen were all removed from the patient early on the first postopera-

tive morning. Ambulation and transfer to a regular hospital room from the intensive care unit was accomplished on the first post-operative morning as well. Generally speaking, patients, regardless of age, are amenable to discharge from the hospital on the second post-operative day.

The results of carotid endarterectomy in this practice were carefully gathered by my surgeon's assistant and tabulated by him. Statistical evaluation, when necessary, was performed by Dr. Edwin Bradley at the University of Alabama in Birmingham.

## Results

There were no deaths or strokes following carotid endarterectomy in this series. Two patients (4%) had transient cranial nerve palsy. One of these was a mild mandibular branch of the trigeminal nerve distribution weakness. Another patient had a mild hypoglossal nerve weakness. One patient (2%) had a transient ischemic attack consisting of a very brief period of dysarthria. This event occurred following the administration of pain medication, but was presumed to be embolic in nature. One patient (2%) had a neck wound hematoma which required re-operation. This occurred in an elderly patient whose blood pressure was not satisfactorily controlled in the intensive care unit. She tolerated re-operation satisfactorily and went home on the second post-operative day as scheduled. No other complications occurred in any patient.

Late follow-up (mean 13 months), although short, reveals no deaths, strokes or transient ischemic

**Table 1**

### Comparison of Medical Therapy vs. Local Carotid TEA

#### Results

	No. Pts.	No. Strokes	%
Medical*	604	136	22%
			p=0.0001
Present Surgical Series	50	0	0%

\*Hennerici<sup>1</sup>, Bogousslavsky<sup>2</sup>, NASCET<sup>3</sup>



attacks. Follow-up carotid ultrasounds on some of the patients, in the course of evaluating the contralateral side, has revealed no post-operative occlusions and no recurrent stenoses.

## Discussion

The role of carotid endarterectomy in the treatment of significant carotid artery disease remains controversial. Hennerici<sup>1</sup> has reported an annual stroke incidence in patients with mild to moderate (50%-80%) carotid stenosis of 2% with an annual transient ischemic attack rate of 7.5%. In patients with severe carotid disease (greater than 80%) an 8.3% annual stroke rate and a 5.6% annual TIA rate was reported. Bogousslavsky<sup>2</sup> has shown a 3.3% annual stroke rate in thirty-eight patients with asymptomatic severe carotid artery disease. The results of the North American Symptomatic Carotid Endarterectomy Trial<sup>3</sup> shows a cumulative risk of ipsilateral stroke at two years of 26% in three hundred and thirty-one medical patients.

For carotid endarterectomy to have a beneficial effect on the natural course of carotid artery disease, the surgical results must be excellent. In 1989, the American College of Physicians stated that acceptable surgical results included a less than 1% mortality and less than 3% major morbidity for patient undergoing carotid endarterectomy.

Gibbs<sup>5</sup> has shown an operative mortality rate of 0.5% in four hundred and sixty-four patients and a rate of permanent stroke rate of 1.6%. Additionally, Fisher<sup>6</sup> has shown an operative mortality of 1.1% in patients under the age of seventy. The Veterans Administration Asymptomatic Carotid Stenosis Study<sup>4</sup> showed a thirty day mortality rate of 1.9% and a stroke rate of 2.4%. The North American Symptomatic Carotid Endarterectomy Trial<sup>3</sup> showed a 5.5% post-operative cerebrovascular event rate. One of these strokes was fatal. Additionally, one other patient died following surgery. The overall stroke and death rate in this study was 5.8%.

My own surgical series, with no deaths and no strokes, is clearly in line with these other published reports.

A comparison of contemporary medical therapy<sup>1,3</sup> for carotid disease and my series of patients undergoing carotid endarterectomy (Table 1) show a statistically significant difference favoring surgical therapy for this disease.

Carotid ultrasound detection of significant carotid artery disease, in my opinion, is quite satisfactory as the sole evaluation prior to surgery. The ultrasounds

seem to be superior to arteriography in the determination of severe ulcerative disease as well. However, arteriography remains the "gold standard" for the evaluation of carotid artery disease.

Surgical details are extremely important if one is to achieve excellent results from carotid endarterectomy. Continuous EEG monitoring and measurement of carotid "stump" pressure with "selective" shunting seems to be an appropriate approach with this group of patients. Full heparinization seems to be useful in the reduction of the risk of thromboembolism and intra-operative and post-operative thrombosis. An "open" carotid endarterectomy allows the surgeon to perfectly assess the distal plaque separation from the intima of the internal carotid artery. I believe that this greatly reduces the incidence of post-operative embolic phenomenon and post-operative thrombosis. Additionally, aggressive debridement of the intima with irrigation of heparin saline will also reduce the incidence of atheromatous debris embolism and post-operative thrombosis. Drainage of the wounds, in my opinion, by suction methods will reduce the incidence of wound hematoma.

Aggressive post-operative treatment will result in a short (3.6 average days) stay in the hospital. Arteriography, as an outpatient, will further reduce the hospital stay as well.

I would, therefore, conclude that carotid endarterectomy should continue to be employed in patients with significant carotid disease, regardless of symptoms, as long as the results of carotid endarterectomy in that surgeon's practice are excellent.

## References

1. Hennerici, M., Hulsbomer, H. B., Heftter, H., Lammerts, D. Rautenberg, W.: Natural History of Asymptomatic Extracranial Arterial Disease. 1987, *Brain* 110:777-791.
2. Boyousslavsky, J., Despland, P. A., Regli, F.: Asymptomatic Tight Stenosis of the Internal Carotid Artery: Long-term Prognosis: *Neurology*, 1986, 36:861-863.
3. North American Symptomatic Carotid Endarterectomy Trial Collaborators: Beneficial Effect of Carotid Endarterectomy in Symptomatic Patients with High-Grade Stenosis: *The New England Journal of Medicine*. 1991, 375:445-453.
4. Towne, J. B., Weiss, D. G., Hobson, R. W.: Veterans Administration Asymptomatic Carotid Stenosis: *Journal of Vascular Surgery*. 1990, 11:252-259.
5. Gibbs, B. J., Guzzetta, V. J., Carotid Endarterectomy in Community Practice: *Annals of Vascular Surgery*. 1989, 3:307-312.
6. Fisher, E. S., Malenka, D. J., Solomon, N. A., Bubolz, T. A., Whaley, F. S., Wennberg, J. E.: Risk of Carotid Endarterectomy in the Elderly: *American Journal of Public Health*. 1989, 79:1617-1620.
7. Callow, A. D., Mackey, W. C., Long-Term Follow-up of Surgically Managed Carotid Bifurcation Atherosclerosis: Justification for an Aggressive Approach: *Annals of Surgery*. 1989, 210:308-316.
8. Baker, W. H., *Diagnosis and Treatment of Carotid Artery Disease*, Second Edition. 1985.
9. Lamberth, W. C., Doty, D. B., *Peripheral Vascular Surgery*. 1987.
10. Krul, J. M. J., Akerstaff, R. G. A., Eikelboom, B. C., Vermeulen F. E. E., *European Journal of Vascular Surgery*. 1989, 3:423-428.

## Acknowledgments

Special thanks to Cindy Scott for her expert secretarial assistance and to Mike Easterling, S.A., for his careful analysis of the data.

# EIGHT GOOD REASONS TO SWITCH HEALTH INSURANCE COMPANIES

---

## 1 LOW RATES

*Compare our premiums to what you're paying now*

## 2 CHOICE OF DEDUCTIBLES WITHIN YOUR GROUP

*Mixing deductibles within your group can help control expenses*

## 3 PERSONAL SERVICE

*We're large enough to meet your needs - yet small enough to care*

## 4 A TRADITION OF TRUST

*We've been serving health care professionals exclusively since 1978*

## 5 AN A+ FOR FINANCIAL STRENGTH AND STABILITY

*Affiliated with Mutual Assurance, rated A+ by A.M. Best*

## 6 A CHOICE OF PROVIDERS

*Total freedom to choose the doctors you want to use*

## 7 RAPID CLAIMS HANDLING

*Most claims paid within two weeks*

## 8 NO PRE-CERTIFICATION REQUIRED

*No administrative headaches or hassles for you or your family*

IF YOU THINK THESE ARE GOOD REASONS  
CALL 1-800 344-9588

**LifeSouth**

PROFESSIONAL'S HEALTH PLAN



# Newly Licensed Doctors

Bentley, Terry Wayne, M.D.  
UAB/Department Psychiatry  
619 6th Avenue South  
Birmingham, AL 35294

Holbert, Kenneth Leo, M. D.  
Huntsville Hospital/Emergency Dept.  
101 Sivley Road  
Huntsville, AL 35801

Branch, Millicent Ann, M.D.  
Lloyd Noland Hospital  
701 Lloyd Noland Parkway  
Fairfield, AL 35064

Kahn, Salma, M.D.  
UAB / Nuclear Medicine  
619 South 19th Street  
Birmingham, AL 35233

Hart, Eileen Marie, M.D.  
UAB / Nuclear Medicine  
619 South 19th Street  
Birmingham, AL 35233

O'Bryan, Roger Leon, D.O.  
7 Bridgecreek Court  
Columbus, GA 31904

Turner, Charles Wesley, M.D.  
111 Rhode Drive  
Hattiesburg, MS 39402

Wilson, Anthony, M.D.  
Lake Shore Hospital  
3800 Ridgeway Drive  
Birmingham, AL 35209

Blumenthal, Scott Lawrence, M.D.  
1201 11th Avenue South

Department Orthopaedic Surgery  
Birmingham, AL 35205

Burton-Shannon, Clarinda Mattea, M.D.  
2107 Putnam Lane  
Mt. Juliet, TN 37122

Carrozzella, John Christy, M.D.  
Department Orthopaedic Surgery  
P.O. Box 11151  
Pensacola, FL 32524

Dean, Kenneth R., M.D.  
3226-C Post Woods Drive  
Atlanta, GA 30332

Dresnick, Stephen Jay, M.D.  
2333 Ponce DeLeon  
Coral Gables, FL 33134

Dvonch, Victoria Marie, M.D.  
3522 Mill Springs Road  
Department Orthopaedic Surgery  
Mt. Brook, AL 35223

Eppstein, Roger Stephen, M.D.  
UAB /Department Medicine  
UAB Station, MEB 621  
Birmingham, AL 35294

Hall, Richard Scott, M.D.  
P.O. Box 1106  
Department Dermatology  
Fairhope, AL 36533

Jahnke, Arlon H., Jr., M.D.  
Chief, Dept. Orthopaedic Surgery  
Lyster Army Hospital  
Ft. Rucker, AL 36362

# AIM HIGH

## **SPECIALIZE IN AIR FORCE MEDICINE.**

ER Physicians. Radiologists. OB/GYNs and other specialists!

Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

**USAF HEALTH  
PROFESSIONS  
TOLL FREE  
1-800-423-USAF**

**USAF HEALTH PROFESSIONS  
TOLL FREE 1-800-423-USAF**





Jarrett, Jeffrey Ross, M.D.  
2725 Warm Springs Road  
Department Cardiology  
Columbus, GA 31904

Jones, Edward Lowry, M.D.  
3457 Sierra Drive  
Department Anesthesiology  
Birmingham, AL 35216

Jones, Rebecca Oldner, M.D.  
Eye Foundation Hospital  
1720 University Boulevard  
Birmingham, AL 35294

Kemp, Elizabeth Ann, M. D.  
725 Airport Road  
Chapel Hill, NC 27514

Kezar, Edwin Paul, M.D.  
P. O . Box 530590  
Department Anesthesiology  
Birmingham, AL 35253

Louisville, Tommy Lee, M. D.  
15 Indian Bayou Drive  
Emergency Medicine  
Destin, FL 32541

McIlwain, Mark Ray, M.D .  
3506 General Bate  
Maxillofacial Surgery  
Nashville, TN 37204

Nixon, Gertrude Elizabeth, M.D.  
810 West Washington Street  
Internal Medicine  
Eufaula, AL 36027

Randolph, Lilly Jean, M. D.  
1809 Heatherbrooke Road  
Emergency Medicine  
Birmingham, AL 35242

Searle, Edward Allan, M.D. 1922  
Seventh Avenue South  
UAB /Department Dermatology  
Birmingham, AL 35233

Stanton, John Howard, D.O.  
117 Black Hawk Drive  
US Army Flight Surgeon

Enterprise, AL 36330

Thompson, Jeffrey Keith, M.D.  
1744 Molly Drive  
Department Radiology  
Birmingham, AL 35235

Thompson, Mandy Malynn, M.D.  
UAB/Department Medicine  
UAB Station, MEB 621  
Birmingham, AL 35294

Tucker, Joseph Allan, Jr., M. D.  
USAMC/Department Pathology  
2451 Fillingim Street  
Mobile, AL 36617

Tuckerman, Myra Beth, M.D.  
36 County Road 3812  
Department Family Practice  
Farmington, NM 87402

Walker, James Whittenburg, Jr., M.D.  
UAB/Department Medicine  
UAB Station, MEB 621  
Birmingham, AL 35294

Williams, Scott Michael, M.D.  
P.O. Box 11151  
Department Orthopaedic Surgery  
Pensacola, FL 32524

Winterland, Anne Woeste, M.D.  
167 Baltusrol Road  
Radiation Oncology  
Franklin, TN 37064

Ludwig, Irene Helen, M.D.  
Eye Center South  
2800 Ross Clark Circle, SW  
Dothan, AL 36301

Zumwalt, Mimi Anh, M.D.  
118 Fieldbrook Drive  
Enterprise, AL 36330

Oliver, Mark David, M. D.  
Carraway Methodist Medical Center  
Department Surgical Education  
1600 North 26th Street  
Birmingham, AL 35234

Hubbuck, Sebastian Otto, M.D.  
1906 Warm Springs Road  
Columbus, GA 31901

Kassels, Mark Allen, M.D.  
USAMC /Mastin Eye Clinic  
2451 Fillingim Street  
Mobile, AL 36617

de Solo, Santiago, M.D.  
511 Hickory Knoll  
Birmingham, AL 35223

Cohen, Michael Victor, M.D.  
6404 Tokeneak Trail  
Mobile, AL 36695

Sparacino, Kathy Jean, M.D.  
Department Family Medicine  
201 Governors Drive  
Huntsville, AL 35801

# Re: *"The Americans with Disabilities Act: Planning for the Disabled"*

Alabama Physical Therapy Association  
Friday, January 10, 1992 Radisson Hotel • Birmingham, AL

How will ADA Affect the Employers, Consultants,  
and Medical Professionals?

Public Accessibility: What is Required?

*plus*

Graham Sisson

Potential Litigation Pitfalls in ADA

Hon. Edwin Nelson

A Federal Judge Anticipates ADA's Impact

Randy Richie  
Ala. Dept of  
Industrial Relations

Status of Workmen's Comp in Alabama

**APTA**

Alabama Physical Therapy Association

For more information call:

PRADCOM Marketing  
(205)990-8612

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992

Above rates are provided by Jackson National Life



# The Alabama Impaired Physicians Program

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ◆ *Intervention*
- ◆ *Education*
- ◆ *Guidence to hospital, staff and employees*
- ◆ *Recovery monitoring*
- ◆ *Structured support groups*
- ◆ *Family assistance*
- ◆ *Advocacy*
- ◆ *Liason*
- ◆ *Quality Assurance*
- ◆ *Confidentiality*

***For information call: 1-800-392-5668 or 205-263-6441***

***On weekends, after office hours and holidays***

***call: 1-205-271-5759***

# When Providing State-Of-The-Art Medical Care Is Not Enough

*Bill Weaver, Ph.D.\**

Physicians often complain that some of their patients seem inappreciative of the efforts made to provide them good medical care. While these patients openly display their dissatisfaction, others may be dissatisfied, even though they conceal it effectively. Furthermore, although some patients are demonstrably appreciative, sometimes these patients, too, may change their opinion about the care being provided them without any obvious reason and without the physician and staff knowing that it has occurred. Thus, providing state-of-the art medical care may not be enough.

Basically, there is a gap between the perceptions held by physicians and those held by patients about what constitutes good medical care. Physicians tend to think that if they get the diagnosis right, prescribe the right treatment plan, and perform any procedures correctly, their efforts should be and will be appreciated by patients. The fact is, however, patients seldom know—at least in the short-run—whether these things have been done correctly. Thus, in the absence of knowledge about medicine, patients make their decisions about the quality of their care on the basis of two things which they do understand: (1) whether they get what they want—some high tech procedure or medication they have heard about, swift action, etc.— and (2) whether they receive personal attention and compassion during their visit to the physician's office or clinic. In short, what the physician believes to be the little things may be big things to patients in assessing the quality of the care they receive. Because perception is often as important as reality, it should be important to every physician who is providing top quality care that his or her patients believe they are receiving top quality care, even if their belief is based on different criteria than those used by the physician.

Why then, is not more attention devoted to the relationship with patients? The two most frequent excuses used by physicians are that there is not enough time and that it is too expensive. Those who say there is not enough time most often are assuming that improving the relationship with patients will require substantially more of the physician's time. While that is a possibility in the short-run, it is unlikely to be so in the long-run. What it will require is that the non-physician staff of the office or clinic become involved in more areas of the patient visit. In the process, staff members who have particular skills and expertise in some areas—sometimes areas which the physician is now covering—may relieve the physician of responsibilities and thus free him or her for more time in other areas. In most cases, the enhanced team approach is particularly important because patients form their image of the health care encounter on the basis of more than the direct encounter with the physician. Thus, reviewing the needs and capabilities of each staff member may assure that each one is assigned a meaningful role that when carried out effectively will result in patients viewing the visit as a positive experience and the providers as compassionate, caring people.

Regarding the cost of devoting more attention to the relationship with patients, it is important to remember that an improved relationship may lead to (1) the patient being more cooperative, compliant, and involved in his or her own care, (2) the possibility that the malpractice threat will be reduced, and (3) the likelihood that satisfied patients will provide free word-of-mouth testimonials on behalf of the physician and his or her staff. More and more, the crucial role of the patient in the recovery process is being recognized and accommodated in the typical medical practice. When the patient can be brought into the process as a partner, the likelihood of medical success is increased. As regards the malpractice threat, there is evidence that patients are more likely to sue a

---

\*Associate Professor of Education in Medicine, School of Medicine, University of Alabama at Birmingham.



For excellent response in the treatment of  
duodenal ulcers...

**AXID**<sup>®</sup> nizatidine

has the right answers

- Rapid epigastric pain relief<sup>1,2\*</sup>
- Fast and effective ulcer healing<sup>2,3,4</sup>



**AXID**  
**PASSES THE ACID TEST**

\*Most patients experience pain relief with the first dose.  
See adjacent page for references and brief summary  
of prescribing information.

## AXID® (nizatidine capsules)

**Brief Summary:** Consult the package insert for complete prescribing information.  
**Indications and Usage:** 1. Active duodenal ulcer—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. Maintenance therapy—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, cimetidine, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid. Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established. Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported. Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.


PV 2091 AMP  
[091190]

### References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol*. 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol*. 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol*. 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request.

 **Eli Lilly and Company**  
Indianapolis, Indiana  
46285

physician whom they dislike but who provides good care than one whom they like but who provides marginal care. Certainly the cost of the malpractice threat is not limited to jury awards but is reflected in costs associated with responding to suits that are won by the physician, suits that never go to trial, and in the medical decisions which physicians make primarily for defensive purposes. Advertising from satisfied patients is not only free but is more meaningful than any advertising which a provider could purchase. The value of this should never be forgotten. Likewise, it should not be forgotten the damage which a dissatisfied patient can do to a medical practice.

Consider for a moment what you and your staff are doing to address the needs of patients.

1. Do you and your staff show that you respect the value of patients' time by avoiding over-scheduling and explaining and apologizing for delays?

2. Do you and your staff set patients at ease in unfamiliar surroundings of your office or clinic by (a) providing information in advance for new patients, (b) providing convenient parking, (c) informing them of the location of restrooms, (d) etc.?

3. Do you and your staff provide clearly personalized attention to patients by (a) looking at them, (b) talking to them, (c) listening to them, and (d) touching them?

4. Are you and your staff considerate of the "special" needs of patients by (a) helping them get out of the chair, (b) helping them find the examining room and get prepared for the examination, (c) being sure that they hear clearly and understand what is said to them, (d) assuring that their sense of modesty is not affronted, and (e) assuring that payment issues are handled confidentially?

5. Are you and your staff open, engaging, and instructive to patients by (a) either refraining from writing in the chart while the patient is explaining symptoms or explaining to the patient that you are listening and recording what is being said, (b) exploring diagnostic and treatment options with the patient, (c) providing instruction that is appropriate to the patient's needs and abilities, and (d) discussing the cost of any options that are being considered?

6. Do you and your staff show a continuing interest in the patient by follow-up telephone contact after any visit in which particularly important or alarming information has been dispensed and after any procedure has been performed?

While patients have needs that should be met, you and your staff also have needs that if not met will impinge on the ability to effectively meet patients'



needs. Consider the needs of yourself and your staff.

1. Do you (a) recognize the limits of your own time and capabilities, (b) use to the fullest the knowledge, capabilities, and interests of each member of your staff, and (c) use your own prestige and authority to authenticate staff members' roles in the eyes of the patient?

2. Do you recognize the crucial importance of teamwork by (a) valuing the contribution being made by staff members, (b) demonstrating a respect for their skills and knowledge just as you expect them to do of your skills and knowledge, and (c) establishing, enforcing, and rewarding staff members for their skills, attentiveness, and professionalism?

3. Do you operate on the belief that (a) every member of your staff has an educational responsibility, (b) patient learning may require the message to be repeated, (c) some patients may learn better from other staff members than from you, and (d) telling patients will be more effective and less likely to lead to misunderstanding if the patient is also given carefully designed written materials?

Much is being said nowadays about quality circles

and empowerment of employees. Because the typical medical office or clinic is a place of business in which the customer—the patient—encounters health care professionals in addition to the physician, it makes a great deal of sense to be sure that all aspects of that patient visit are being handled with the same degree of professionalism and consideration. This effort can be accomplished by assessing the community, the patients, the characteristics of the physician and each staff member, and devising a means by which the skills, expertise, and personality characteristics of each person—including the physician—are used in the area(s) in which they are most likely to produce the desired results.

What can be gained by this effort? It seems reasonable to assume that patients will be more pleased with their care, staff members will be more enthusiastic about their work because they see their role as a more important one, and the increased harmony and attentiveness will be effective in improving the image in the community and increasing the number of patients who are attracted to that harmonious and attentive atmosphere.

## Associate Medical Director

One of the Southeast's leading insurance concerns is seeking a physician to serve in the position of Associate Medical Director. This individual will have responsibility for a variety of functions including claims review, assistance with medical underwriting, handling liaison work with professional groups, development of medical guidelines, and work with cost containment and utilization review programs. To qualify, applicants must have 5-10 years successful experience as a practicing physician, preferably in a family practice, internal medicine, or general surgical setting. A current license, board certification and exceptional communication skills are also required. The position will provide the advantages of a professional medical environment including regular office hours, high visibility, and a stable work setting without liabilities of an independent practice. Compensation will be based on the overall qualifications and experience that you can offer. Our benefit plan includes:

- 401(k) tax-deferred savings program
- two weeks vacation and 9 paid holidays
- fully funded retirement plan/vested after 5 years
- disability/travel and accidental death coverage
- life insurance provided at twice annual salary free of charge/additional coverage available at low cost
- personal and family dental insurance at reduced rate
- dependent care assistance plan available
- tuition reimbursement policy/one medical meeting at company expense-not taken from vacation time
- generous military/reserve leave policy
- gainsharing program
- pleasant working environment/excellent experienced support staff, as well as other incentives.

Send curriculum vitae and salary requirements to:

Elizabeth Hamlin/Employment Manager  
Blue Cross & Blue Shield of Alabama  
450 Riverchase Parkway East  
Birmingham, AL 35298



Blue Cross  
and  
Blue Shield  
of Alabama

The Caring Company

Equal Opportunity/Affirmative Action Employer

# THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

## \$10,000 - \$20,000 - \$30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**



# The Health Care 'Industry'

*K.L. Shaffer, M.D., F.A.A.P.  
Nebraska Medical Journal*

Much has been written and spoken about the skyrocketing costs of medical care in the United States, and much as has been written and spoken regarding the problems of our health care system in the United States. We now have many proposals about changing our health care system, including rationing of health care as a means of controlling costs. Perhaps more fundamental issues need to be addressed.

Webster's dictionary defines medicine as the science and art dealing with the maintenance of health and the prevention, alleviation or cure of disease. In medical school and residency few of us ever heard mentioned anything about coding, gross billings, collection percentages, etc. I submit, in the last three decades, medicine has evolved into a business as much as a science and art. Webster defines business as a term that may be inclusive, but specifically designates the activities of those engaged in the purchase or sale of commodities or in the related financial transactions. Most of us would agree that one is in business for profit. Where there is profit in our society, there is competition for the dollar. The United States has subsequently developed a "health care industry" that has become a major economic factor in the United States. This industry has also become the major cost factor of medical care in the United States.

This health care industry has developed into medical supply companies, pharmaceutical companies, insurance companies, hospitals, physicians and their offices, and even the legal profession has become a significant part of this health care industry. We see medical supply companies charging inflated prices for our equipment because the "market place" will tolerate these prices. These products are advertised and marketed widely. We have pharmaceutical companies promoting their medications by spending millions in advertising via mail that swamps our desks, pharmaceutical representatives who swarm our offices, and the offering of "educational" conferences promoting their medications. We have insurance companies that spend millions advertising their packages or coverage, that spend millions on administrative costs of

processing claims (and writing numerous letters of inquiries to doctors' offices before payments are made) and insurance companies that spend millions of dollars trying to manage care of their participants through pre-admission review and utilization reviews that are of questionable cost benefit. Yet, these same insurance companies are unwilling to pay for preventive care. We have insurance companies selling malpractice insurance that have been paid millions of dollars to build up "reserves" for future lawsuits in years to come. We have hospitals that have spent millions of dollars on marketing and advertising services for the public, hospitals that add or expand services, often more for the bottom-line than for patient care, and hospitals that have millions of dollars in "reserves". We have a legal profession that has created a segment of their profession whose livelihood relates mainly to malpractice suits that have tremendously escalated the cost of medicine. Many of these lawsuits have no medical malpractice but are results of a disease or disease process of unfortunate patients.

Do we also have physicians who are overpaid? A recent Medical Economics article (June 17, 1991) showed that doctors were well paid, but that few other professionals put in the hours that physicians devote to their practice of medicine. Many of us also face enormous stress and emotions in helping our families and patients with difficult life decisions. However, we have allowed physicians to be rewarded for the number of procedures they perform or the number of patients they see. I believe all of us would agree that some physicians, especially in certain specialties, are grossly overpaid for the services that they deliver. All of the health care industry also actively lobbies Congress and Legislatures, spending millions of dollars regarding health care. Often these efforts are very nearsighted and often a segment of the health care industry tries to improve their status, therefore insuring continuing profit in their segment of this health care industry.

I submit that perhaps we need to look at the profit of medicine and attempt to find ways to control this,

*continued on page 27*



# You Shouldn't Choose A Debt Collection Service The Same Way You Choose Your Plumber.

While you're thumbing through the yellow pages, your debtors are thumbing their noses at you.

It's time to get serious. And put I.C. System to work for your business. I.C. System has been endorsed by over 1,100 trade and professional associations just like yours and has collected millions for members just like you.

Our methods are ethical and highly effective, our newly expanded range of

collection programs are the most technologically advanced in the country.

We'll go after your consumer or commercial debts, and we'll do it anywhere in the country. Next time skip the Yellow Pages and call I.C. System direct.

**1-800-325-6884**



**I.C. SYSTEM**



# Survey Underscores Changing Attitudes of Young Physicians

*Phil Miller\**

The majority of medical residents today receive over 50 offers of employment, expect to make at least \$100,000 or more their first year of practice and would prefer an HMO or group setting to a solo setting, according to a survey conducted by Merritt, Hawkins & Associates, a national physician search firm based in Dallas, Texas.

The survey of 100 third-year medical residents indicates a continued shift away from traditional patterns of practice toward "9 to 5" medicine, Joseph Hawkins, chief executive officer of Merritt, Hawkins & Associates, said.

"The days when physicians put out a shingle and spent 70 to 80 hours a week performing hands-on care are long gone," Hawkins stated. "Physicians today expect different things from medical practice. They seek financial security and enough time away from work to enjoy life. Because demand for their services is so high, young physicians are in a position to obtain what they want."

Eighty-six percent of physicians surveyed had received at least 50 job offers, underscoring the current demand for physicians. Sixty-five percent of residents responded that they had received 100 or more job offers. Though many of these offers are from smaller, rural communities, 79% of residents surveyed would prefer to practice in mid-to large-sized communities. Only 5% of residents expressed a desire to practice in communities of 25,000 or less.

When asked which type of practice setting they would prefer, 69% of residents indicated either a group or HMO setting as a first choice. Only 8% of respondents preferred a solo setting, and only five percent preferred a partnership.

"Partnerships are where all the horror stories are generated," Hawkins observed. "Young physicians hear about partners who are domineering, whose

spouses interfere or who don't stick with agreements," Hawkins observed. "Few physicians today want to risk a bad professional marriage."

The marginal preference for solo settings highlights an even more disturbing trend, Hawkins said.

"The doctor used to be the ultimate example of the small entrepreneur whose practice was not a job, but a way of life," Hawkins stated. "Today, changing technology, bureaucratic hassles and malpractice worries have made solo practice seem like a trap to many young physicians. They prefer the support and security of HMOs or groups."

The trend away from entrepreneurial medicine also is reflected in the type of payment preferences that survey respondents revealed. Sixty percent of residents surveyed said they would prefer a salary as a form of compensation in their first practice. Twenty percent indicated a preference for an income guarantee. Only 15% preferred the standard fee for services form of payment by which physicians have traditionally been compensated.

"These payment preferences show the premium young physicians place on security and structure," Hawkins explained, "Because of convoluted third party payer schemes, physicians today would prefer the structure of a regular salary. Since young physicians carry an average debt of over \$40,000, they also seek the security of an income guarantee."

Hawkins contrasts these preferences to those of the old-style physician, who typically took out a bank loan to set up his or her first practice. None of the residents surveyed indicated a preference for a bank loan.

The survey also indicated that residents have a good idea of their value in the marketplace. Ninety-one percent of residents surveyed indicated that they expect to make at least \$75,000 to \$100,000 their first year in practice. Fifty-nine percent of residents surveyed expect to make \$100,000 or more.

Residents' financial expectations are not out of line with reality, according to Hawkins. Primary care

---

\*Triton Communications, 222 W Las Colinas Blvd., Suite 1920, Irving Texas 75039, (214) 444-2220 . FAX (214) 444-2221.

physicians such as family practitioners and internal medicine practitioners can expect to make guaranteed salaries of \$100,000-plus. Those in specialties such as cardiology or oncology can expect to make \$125,000 or more their first year, Hawkins said.

"This level of compensation may seem high, but, prorated over the length of their respective careers, most physicians make no more than lawyers or business executives," Hawkins observed.

Though the survey shows the further erosion of traditional medical practice, Hawkins remains upbeat about the quality and character of young physicians today.

"The essence of the physician-patient relationship — what's known as bedside manner — has evolved away from what it used to be for many reasons," Hawkins said. "Nevertheless, young physicians today are better trained and more motivated to provide quality care than they have ever been. As a potential patient, I feel secure about the care provided by young physicians today."

## The Health Care 'Industry'

*continued from page 24*

rather than rationing care of our patients. Let's stop the advertising and marketing by medical supply companies, pharmaceutical companies, insurance industries, hospitals and doctors' offices. Let's begin to promote preventative care and reward individuals who get their children immunized, use seat belts, avoid smoking, alcohol and other drugs, and who exercise and eat intelligently. Let's stop the proliferation of services that hospitals and physicians develop that are more interested in the bottom-line than in the medical necessity of these services. Let's invest the millions in reserves and profits that our hospitals and insurance companies have in our underinsured population. Let's alter the current practice of medicine and the current practice of law to serve our patients and clients and stop trying to make a dollar. Let's encourage our Congressional and Legislative leaders to take a long look at our capitalistic health care system and not attempt to regulate one segment of this industry.

As Dr. John Ring, the newly inaugurated president of the American Medical Association, recently stated, "I'd like to encourage my colleagues to enhance their devotion to the ethics of medicine rather than to the ethics of marketplace."

**When you  
don't know  
all the medicines  
your patients are taking,  
protecting their health  
is a crap shoot.**



Many patients may be risking their health by combining prescriptions and/or OTCs that shouldn't be mixed. Uninformed medicine use is risky. Especially for older patients.

Counseling patients about all their medicines improves their odds of getting well and staying well.

Write to NCPIE for a free medicine counseling kit.



**EVERYONE WINS WHEN YOU TALK**

**Please send me a free Medicine Counseling Kit.**

Name \_\_\_\_\_

Organization \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

**Mail to:**

National Council on Patient Information  
and Education  
666 Eleventh Street, NW, Suite 810  
Washington, DC 20001  
To fax your request -- (202) 638-0773



# Just Send the Bill to Blue Car and Blue Truck

*Alieta Eck, MD\**

*Association of American Physicians and Surgeons*

Everyone knows that all gas station owners are filthy rich (we're not sure how rich, but definitely too rich) and all senior citizens are very poor. Thus, I am surprised that our compassionate congressmen have not come up with a Social Gasoline Security Act yet. All senior citizens deserve unlimited mobility and, regardless of how wealthy they might be, should not have to pay a fair market price. The government ought to foot the bill. Having had considerable experience in a similar program, I would like to outline how Mandatory Gas-O-Care Assignment would go.

A gray-haired motorist would drive up to the gas station. Twenty dollars worth of gasoline would be pumped into his car, but the attendant would then simply smile, tip his hat, and accept no payment at this time. As of September 1, 1990, because our legislators see senior citizens as not only poor but also inept at paperwork, the wealthy gas station owner would then have to fill out a lengthy form and submit it to Blue Car and Blue Truck of Pennsylvania. He would not be able to charge the senior for this paperwork service. After all, he's got all the bucks. Never mind that his employees need to be paid right away, his rent and utilities cannot wait, and his suppliers demand payment when the gasoline is delivered to the station. He is rich, and he can wait. After four to five weeks or so, he would receive a check from Blue Car and Blue Truck with the following explanation of benefits:

You have charged \$20.00 for this senior's gasoline. But we in the government bureaucracy have approved only \$12.00 for this service. We thus would issue you a check for 80% or \$9.60. You may now bill your patron for the copayment of 20% or \$2.40. But, we are sorry to say that the government finances are in a bit of a mess, and the Gramm-Rudman Deficit Reduction Act compels us to reduce our check to you by 2.92%. You are not allowed to bill the customer

for this extra \$0.28. If you do, we will fine you \$2000 if we find out. Here is your check for \$9.32.

Now many seniors would think this is a great deal. They get \$20 worth of gasoline for just \$2.40. But I am afraid that the gas station owners might feel a bit cheated. They might try a few survival techniques. They might allow only a small number of seniors to pump gas at their stations, or they might choose to specialize in only young drivers. Very few would go into time-consuming specialty training to learn to care for the elderly car owner's special needs. And those who did so would never be able to own their own gas stations.

Many gas-station owners would move out of New Jersey. Many would retire early to avoid this aggravation. And, finally, the brightest young people would no longer vie to get into gas-station school. The fact that gas-station owners need 8 to 12 years of expensive training (up 400% in the past 10 years); the fact that they need to be available 24 hours a day; the fact that they must purchase costly malpractice insurance because there is a lawyer behind every bush waiting for an attendant to spill some gasoline—all these facts are ignored when the government sets its "approved" rates.

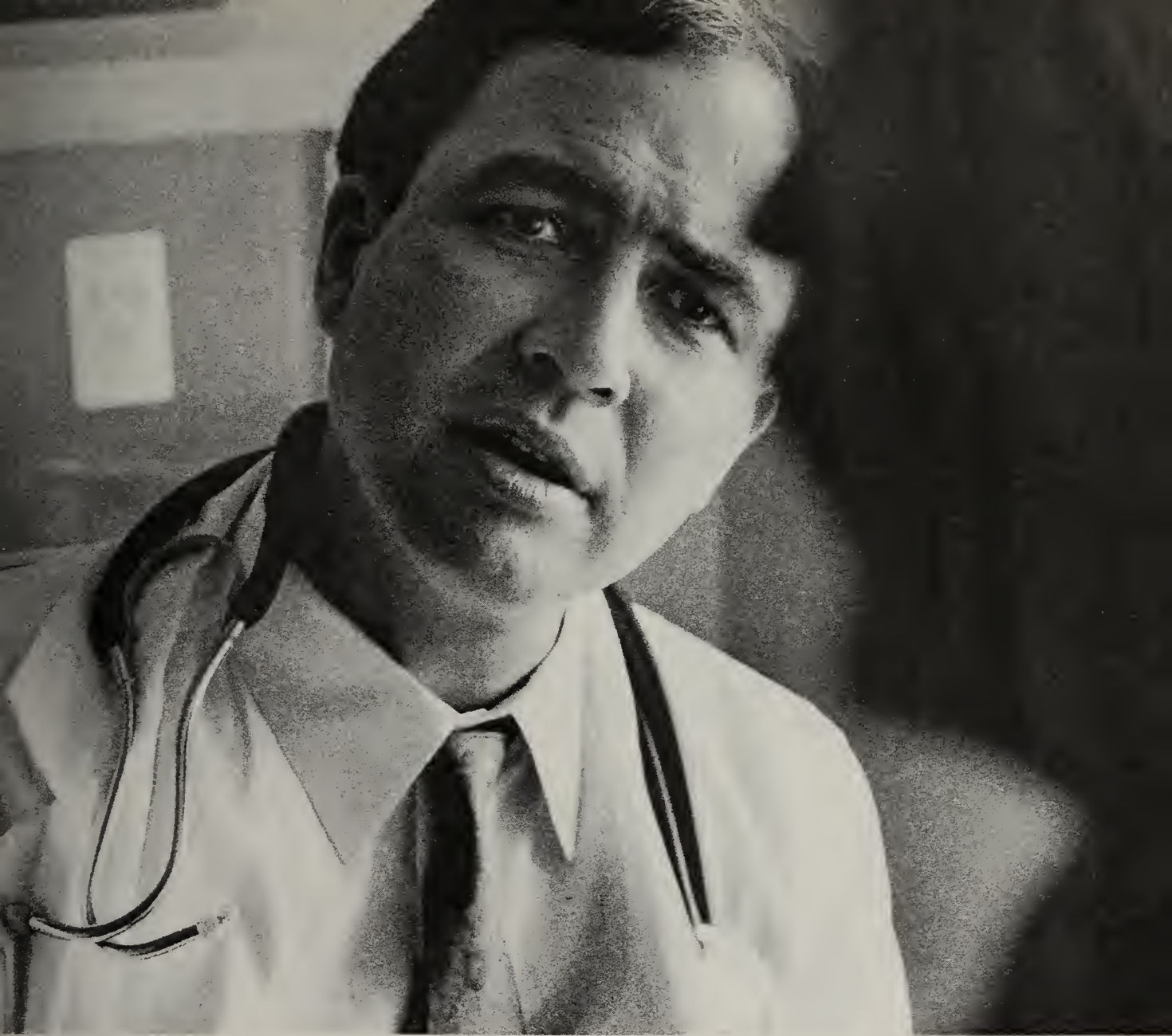
Our legislators feel that all senior citizens—even Bob Hope and Ronald Reagan—deserve a break. No senior should be discriminated against. I am sure that all caring, altruistic gas station owners worth their salt will gladly accept this unprecedented government intrusion into the gas-station industry.

But there might be some self-centered diehards. So we might have to get a bit tough. We could make their gas-station licenses depend on not discriminating against seniors. We could make it illegal to try to sell their stations and leave the state. We could hand-pick the best and brightest young people and compel some of them to enter gas-station school.

If we run out of ideas on how to make this plan work, we could send a delegation to the Soviet Union for inspiration and training. After all, they've had 73 years experience with this sort of thing.

---

\*Piscataway, New Jersey. A greatly abbreviated version of this essay appeared in *AM News*.



## "We must make sure that policies are based on facts, not fears."

Dr. Paul Volberding, Researcher, University of California, San Francisco, Member, American Medical Association

Amid the rancor of politics and budget debates, the needs of the patient are often overlooked. And, it is forgotten that it is physicians who know the most about disease and the suffering of patients.

Nowhere is this more true than with AIDS.

"Throughout the history of epidemics, there has been the possibility of reactions and policy based on fear and stigma," states Dr. Volberding.

The American Medical Association (AMA) agrees. The AMA is committed to fair AIDS policies, and to supporting researchers battling not just AIDS, but the countless diseases that ravage our society.

"What impresses me most about the AMA is its

willingness to take public policy positions and its ability to influence opinion," Dr. Volberding adds.

You are invited to join Dr. Volberding and to join with him in his efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

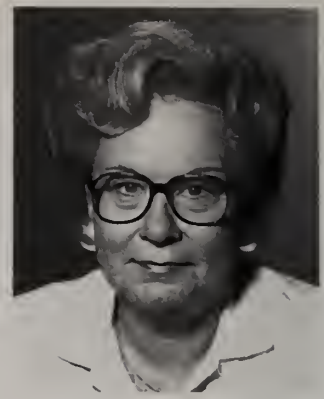
Members of the AMA are encouraged to join their state, county and specialty societies.

**American Medical Association**

Physicians dedicated to the health of America







*Mrs. Stuart K. Bean  
A-MASA, President*

## Dr. & Mrs. Richard Shepard

*By Donna Specker*

*Media Chairman, A-MASA*

When NASA went looking for someone to head their first committee on medical experiments for the space shuttle, they sought out Dr. Richard Shepard, professor of surgery at U.A.B. What they got was a very "people oriented" cardio-thoracic surgeon with a degree in physics and a wide ranging interest in medical research.

But Dr. Shepard is only part of a family that Alabama can be very proud of. Wyness, his wife, is active in many civic projects including the Birmingham Botanical Gardens, the Birmingham Humane Society, Southern Medical Association Auxiliary, and the Jefferson County Medical Auxiliary. The Shepards' also have three talented children; two are physicians and one is a student of movie production in California.

Dr. Shepard's involvement with NASA came about because of his early studies on the extended use of heart-lung machines. He wrote a paper that was published by the University of Tokyo in association with the Aerospace Medical Association. The paper caught the attention of scientists at the University Space Research Association, who asked Dr. Shepard to form a committee to evaluate medical experiments for the first seven space shuttle flights.

Along with experiments on astrophysics and astronomy, NASA needed someone to rate medical experiments proposed by U.S. and European scientists. These had to be evaluated from a scientific point of view to determine not only which experiments should receive priority but which ones were "doable." NASA then made final decisions based partly

on the space requirements and power requirements as well as the safety of the experiments. Proposals came from such fields as internal medicine, bacteriology, and physiology, and dealt with questions bearing on space travel and everyday medical problems.

One of Dr. Shepard's benefits of working with the space program is a longstanding friendship with astronaut and physician, Dr. Story Musgrave. Dr. Musgrave, who flew on one of the most recent shuttle flights, encouraged Dr. Shepard to be more active in the space program. "I thought for a long time that I would like to go up in the space shuttle," says Dr. Shepard, and at one time considered becoming a payload specialist. He already has a commercial pilot's license with instrument rating, but he decided to continue his commitment as a surgeon.

Today Dr. Shepard's degree in physics still influences his medical interests. He has studied, along with Dr. Joaquin Aldrete of U.A.B., techniques for measuring the electrical potentials on the abdominal wall to understand what is happening inside the abdomen, similar to the way an electrocardiogram reports on the heart. Dr. Shepard says progress has been made in showing that when the intestine is not working correctly, as in after surgery, the electrical activity is not "right."

Dr. Shepard also performs cardiac surgery inserting pacemakers and self-contained defibrillators that detect tachycardia or ventricular fibrillation and automatically shock the patient's heart. His areas of interest include non-traditional cardiac specializations and what he calls "this physics stuff." Some of his



## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association



patients include newborns delivered so they can have a pacemaker implanted. He is now writing a new chapter in the forthcoming book *Advances In Cardiac Surgery*, and has written articles on ambulatory defibrillators, pacemakers and "electronic" medicine.

Dr. Shepard thinks a doctor needs to be a person first, then a doctor, and a specialist next. Talking to him it is clear that he is also an enthusiastic thinker, a concerned physician and a very proud father.

---

## ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

---

FP, IM, GP needed in rural South AL flourishing practice. Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

---

FPS and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

---

ER PHYSICIANS NEEDED for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

---

Busy five-member internal medicine group seeks an associate/partner to join their practice due to the planned retirement of one of their members. The practice admits to a 346-bed general acute care hospital connected to the doctors' office building. With a service area of over 400,000, the medical community is very progressive and all medical specialties are well represented. Located in the beautiful mountain/lakes region of northern Alabama, this community was recently honored by receiving the 1991 "All-America City" award. A growing and well-diversified economic base; the best in schools, recreation, and affordable housing make this an excellent opportunity. Send curriculum vitae to: Alabama Medicine, Box A, P.O. Box 1900, Montgomery, AL, 36102-1900.

---

BC/BE FAMILY PRACTICE OPPORTUNITY—Practice position with two established BC Family Practice Physicians in Tuscaloosa. Four day work week with above average income. Strong established patient base. Community of 120,000 offers excellent cultural and family environment. Relocation and income security available. Contact: Jeff Caples, 339-9726.

### INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be type-written, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.

# Your Telephone System May Have a Surprise in Store for You.



Ask yourself these questions, if you want to prevent costly problems.

- **Is your telephone system four or more years old?**

If so, let us show you how prices have come down since then. You may be in an advantageous position to trade, especially when you consider the increased costs of maintaining an aging telephone system.

- **Do you spend more than \$500 a month on telephone services?**

If you do, we'd like to audit your expenses to make sure billing is accurate and costs are in line. There may be several ways to save.

- **Are you planning to move your telephone equipment in the next six months?**

If you are, let us give you a free comparison on moving your equipment or trading it in on a new system with a two-year warranty.

- **Can your present system be modified to handle more calls?**

Very likely. There are new message handling and routing services that could make your system much more productive, without adding to your equipment cost.

- **Did you know there are new rate structures available for business telephone service?**

Absolutely. We'd be glad to discuss them with you to see if any new rates would be good for your business.

Because your business is on the line, call COMTEX today for a free, comprehensive telephone system check.

 **COMTEX**  
INTERNATIONAL  
*A Total Communications Company*  
Birmingham • (205) 871-3000  
Montgomery • (205) 271-4000





The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6143V

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

A91CA6148T

When diet and exercise alone are not enough...



ONCE DAILY 180mg Calan SR Verapamil HCl 180mg SUSTAINED-RELEASE CAPLETS

A MILD START IN MILD HYPERTENSION

MS

© 1991, G.D. Searle & Co.

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA



THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

FEB 04 1992

FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
10 SHATTUCK STREET  
BOSTON, MA 02115-0000

## MASA's Dr. Summer: He's Been There

pg. 7

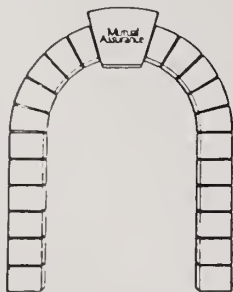


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 6, DECEMBER 1991

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1991 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Myers, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Jael C. Pittard, M.D. (1992); Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At Large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

### EXECUTIVE DIRECTOR

S. Lon Corner

Secretary-Treasurer - Emmett Wyatt

### DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

FRANCIS A. COUNAWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

## In This Issue

FEB 04 1992

Executive Director.....2  
*A MASA Milestone*

President's Page.....4  
*Keep The Faith*

*Dr. Summer: He's Been There*.....7  
William H. McDonald

*Alabama Impaired Physicians Program*.....13  
Gerald L. Summer, M.D.

*UAB Medical School Deans*.....16  
Alston Callahan, M.D., F.A.C.S.

Classifieds.....26

*Turtle Mountain Chippewas*.....29  
Wm. Harold Avant, M.D.

Newly Licensed Physicians.....31

## Cover

Gerald L. Summer, M.D., medical director of the Alabama Impaired Physicians Program, knows his subject from the outside in and the inside out. Dr. Summer believes that the involvement of families is crucial to the recovery process. He is shown here with his wife, Andrea, a student of addiction now working on her Master's degree in psychology.





*S. Lon Conner  
Executive Director, MASA*

## A MASA Milestone

I can think of no better way of starting the new year than in saluting the presence of a highly qualified full-time medical director of the MASA Impaired Physician Program.

Gerald L. Summer, M.D., who was selected to head the MASA program, came on board last fall. As you will see upon reading the profile of him in this issue, he hit the ground running. Dr. Summer has made it plain he will not be satisfied with a good program; he is shooting for the best in the country.

The program had its inception 13 years ago when the 1977-78 President of MASA, John B. McFerrin Rice, Jr., M.D., proposed what was then a rather radical idea — that doctors owed it to their profession to attempt to salvage the lives of those colleagues who fall victim to substance abuse.

My own intense interest was born at that time. In 1984-87 I served as the only non-physician on the AMA Impaired Physician Advisory Committee. Although I have no such problem myself, I have had friends who became addicted and I have attended AA meetings with them. "There but for the grace of God go I" pretty well says it all for the overwhelming majority of physicians who have seen colleagues suffer.

While the country has become rightly alarmed over the use of street drugs, which seem to have infected even the smallest towns in the land, the most dangerous drug of all, some say, has been here for centuries — alcohol. And it is the drug of choice for most impaired physicians, despite their easy access to other potent chemicals.

Genetic research offers some promise that in the future there may be bioengineered solutions to addiction, which is no respecter of persons or socioeco-

nomic class. Until then, we must deal with the consequences of addiction in the wholistic approach described by Dr. Summer in this issue. It works, and Dr. Summer is himself Exhibit A of how well it works. Before the present enlightenment, he might have died of the disease instead of triumphing over it to become a healer for other physicians. In the short space of less than a decade, Dr. Summer has attracted the approving notice of some of the pioneers in impaired physician work. For example, G. Douglas Talbot, M.D., founder of Georgia's landmark program, recommended Dr. Summer as simply the best available man for the job, period.

Many Alabama physicians gave years of their time to bring the Association's program to this point, a defining moment. William J. Tally, M.D., chairman of the Impaired Physicians Committee, has worked on the program from the very beginning.

Dr. Summer will need the help of many hands to achieve his objectives and I know that help will be forthcoming. Not least will be the role of the Auxiliary in involving itself in meaningful support of the families of impaired physicians. Shattered, dysfunctional families must be treated along with the physician.

In closing I would like to introduce a question already raised by Dr. Summer — a new name for MASA's program. He thinks, and I believe he has a strong point, that "impaired physician" is loaded with negative connotations. The Florida program where he first trained for this work had a far more upbeat name — PRN for Physicians Recovery Network — which properly accentuates the positive. I would appreciate any suggestions in this connection.

Best wishes for 1992.



# SYSTEMS CORPORATION

Medical Systems Consultants

Suite 2108, First National Bank Building

Mobile, Alabama 36602

1-800-239-1717

(In Mobile, call 432-1313)

## Universal Electronic Billing !

- (1) Now your practice can electronically bill all third party payors — in care of one location.
- (2) Now you can put more money in your pocket, much faster!

### Your Cost Today?

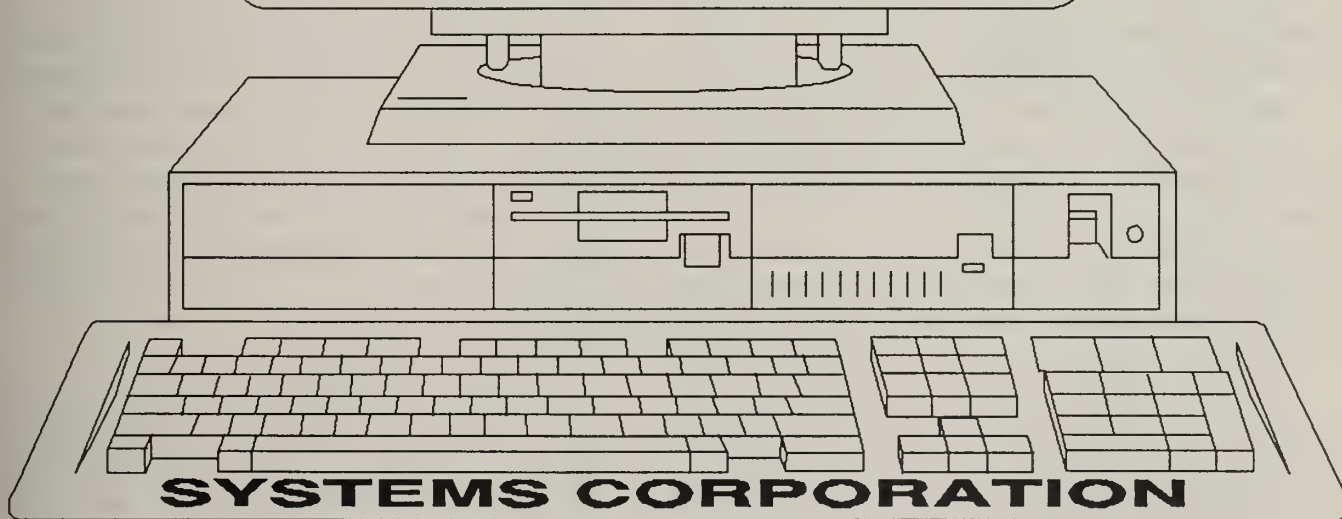
\$695 for the software — installed in your

office — on your machines!

45¢ per Electronic Charge transmitted!

For Further Information, Please Call:

**1-800-239-1717**



### Comparisons

- |     |   |
|-----|---|
| I.  | In 1990, the administrative cost of processing a paper claim approximated \$3.50. Utilization of our Electronic Billing System can today reduce costs to \$1.50 per claim, approximately. |
| II. | Reimbursement from paper claims can take 7-8 weeks versus 2-3 weeks from Electronic Claims.   |





*William D. Lazenby, M.D.  
President, MASA*

## Keep The Faith

The year past was one of turmoil, some continuing and some just beginning, for U.S. physicians. The eve of the inauguration of the Medicare RBRVS propelled us into battle against the totally unexpected, and illegal, 16% cut in the conversion factor.

Although Congress had enjoined the administration not to use physician payment reform as a budget-cutting tool, that was attempted anyway. Worse, this was denied by HCFA even as it wiped the egg from its face.

Orchestrated by AMA and by MASA here in Alabama, many thousands of physicians protested this act of perfidy, which flew in the face of repeated promises not to use the new system as another meataxe to cut Medicare. The opportunity, however, was too tempting for the likes of Budget Director Richard Darman who appeared to be calling the shots for HCFA.

In the end, we won restoration of most of the slashed funds — the result, I might add, of the unity of American physicians, who brought their influence to bear in a mighty wave of indignation. Something over 80% of Congress signed on in support of our claim that we had been treated shabbily and dishonorably by the bureaucracy, which chose to renege on Washington's promises in as bald-faced an attempt as I have ever seen to usurp the functions of representative government.

Considering the congressional support for our position, some physicians have conjectured that if we stonewalled everything we don't like in such a fashion as this, we would win them all. I am afraid this is wishful thinking; we won this one precisely because

we had not cried wolf on every occasion. We must save our big guns for the big battles. It is bootless to go for broke on everything.

And there are many big battles looming over the horizon of 1992. AMA has hinted of even more perilous conflict ahead. I think I can detect a kind of Armageddon shaping up in the almost universal demand for some form of national health care. Since 1992 is a presidential election year, I expect the political cacophony to intensify as the year progresses.

If the Republicans and Democrats slip into a bidding war, as each tries to outdo the other in promises to the electorate, the public is at risk; so, of course, is medicine. Since the federal debt now approaches \$4 trillion, and continues to skyrocket ominously with every new deficit budget, none of those making the outrageous promises has any idea of how to pay for their moonbeams. The country is virtually broke. Since none of the political hucksters wants to propose new taxes to pay for their schemes, the debate may boil down to something like this: "My free lunch is better than your free lunch."

Suppose, then, that before the year is out, a revolutionary health care bill does make it through Congress just in time for next November's elections and has, like the lady of the evening, no visible means of support. In the end, unless we are wise and courageous in battle, patients and physicians will pay for congressional overpromising — as both are paying, even now, for past overpromising.

It is easy enough to develop a garrison mentality and simply hunker down until the cannonading is over. But we can't do that for the obvious reason that

# Whose Retirement Plans? Not Yours - That's For Sure !

**Think About All The Retirement Plan Costs You Pay. Lawyers - Trust Departments -**



**Stock Brokers - Accountants - Investment Advisors - Plan Administrators - ETC., ETC., ETC.**

**Only Incredible Investment Returns Would Save Your Retirement Money From Being In a Perpetual Bear Market !**

**Would You Like To Convert To Retirement Plans**



**Which Grow Assets For You?**

We offer complete investment management on an individualized basis for every physician as well as complete retirement plan services which include every service listed above.

Our comprehensive system will net most physicians more profit on their retirement monies than other alternatives.

Our charge is an inexpensive % of your assets under our management.

## **INVESTMENT ADVISORY & MANAGEMENT CORPORATION**

Suite 2110 First  
National Bank Building  
Mobile, Alabama 36602

1-800-239-1666  
In Mobile (432-1666)



And, if we don't obtain good results for you, our compensation suffers.

References? Yes. We have the support of our existing physician clients — and they are very willing to discuss our services for them with you.

For references or further information, such as a copy of our free retirement plan services pamphlet, please contact us.

**Registered Investment Advisor**

**With the U.S. Securities Exchange Commission and The States of Alabama and Mississippi**



down the way, when the 1992 monstrosity collapses, public and politician alike will be quick to blame doctors again.

In 1964-65, organized medicine warned that Medicare would bankrupt itself. In 1991 we are the villain of that collapse. We are forever being convicted by the circumstantial evidence that when over-promised and underfunded programs collide with reality, who is always at the scene of the accident? Doctors, of course; therefore, we are the culpable parties.

So weary have many doctors become of this struggle, they take French Leave and go over the hill, leaving the war behind. Appealing as that may be a times, it would be suicidal. When King Richard urged his bloodied troops back into the fray at the epochal Battle of Agincourt, he could have been speaking for the leaders of organized medicine when he exhorted: "Once more unto the breach, dear friends, once more."

We must never surrender despite the demagoguery that 1992 is likely to produce.

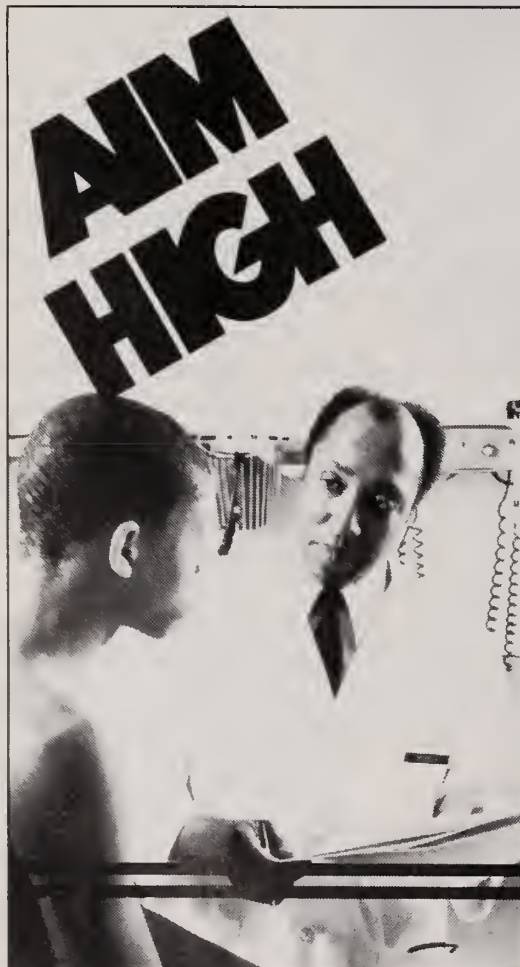
All the while, managed care, the euphemism of

rationing, proceeds apace, ranging the full gamut from the reasonable to the ridiculous. The profusion of impediments and strictures on our practice induces a kind of numbness. I caution all doctors not to let their displeasure blight the wondrous gift of healing. Throughout history, doctors have continued to care for their patients under heavy bombardment that jeopardized their own lives. They have continued to do their duty in fearful plagues knowing they might not live to see another dawn.

Can we do less?

For 1992, the committed physician does not ask for political peace and tranquility, knowing those will not be his lot, but only for the serenity to do his job and keep his head even when all about him seem to be losing theirs.

Whatever passions may be unleashed in the months ahead, whatever nonsense may fill the air, my wish is that you shall continue to find your greatest happiness in the totally dedicated practice of our science and art. That is the tradition handed down to us; it is the tradition we owe posterity.



## CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

**USAF HEALTH PROFESSIONS**  
**TOLL FREE**  
**1-800-423-USAF**



# Dr. Summer: He's Been There

*William H. McDonald*

Gerald L. Summer, M.D., gave no thought to medicine as a career when he was growing up in the little town of Newberry, South Carolina, just up the pike from the capital, Columbia.

That came in his junior year at the Citadel. Looking back, the Medical Director of MASA's Impaired Physician Program admits to being a little bit naive when he finally made the decision.

"I thought I could cure the world," Dr. Summer says now, with a self-deprecating smile of remembered conviction. Complete candor is his style, a studied openness that may derive from his own continuing introspection.

The Board of Censors selected Dr. Summer, 54, from an impressive list of candidates for the job, after many years developing the MASA program. His medical credentials were impeccable but there was another dimension to him that was immediately apparent and it proved compelling.

After earning his M.D. at the Medical University of South Carolina in 1962, he served two years in the Public Health Service, followed by residency in Internal Medicine at South Carolina and a cardiology fellowship at Emory.

He practiced medicine in West Palm Beach, Florida, for 20 years, the senior member of an established group. For four years, he was medical director of a 65-bed substance abuse center in West Palm Beach. He has presented papers on substance abuse before the AMA National Conference on Impaired Health Professionals, the American Society of Addiction Medicine, and the Alcohol and Drug Problems Association.

The Medical Director of Florida's highly regarded Physician's Recovery Network (PRN), Roger Goetz, M.D., had hoped to sign on Dr. Summer as his assistant but the requested appropriation was not forthcoming. Dr. Summer had worked closely with the program for several years. Dr. Goetz says of him:

"In my professional opinion, Dr. Summer is the best available candidate to direct an impaired physician program in the United States."

All this impressed the Board of Censors, but Dr. Summer had another leg-up on his competitors, one

that gave him the advantage, as Mark Twain once said, of "a Christian with three aces and a Smith & Wesson" — he is a recovering physician himself and plainly a man with a driving mission: he believes profoundly in the work he is doing. Rebuilding his own life has given him the insights and the calling to help other physicians. It is believed that substance abuse among physicians occurs at about the same percentage as in the general population.

Alcohol was his problem, one that had its genesis, he now acknowledges, in the alcoholic family in which he was raised and, later, in his choice of buddies at the Citadel: "I always selected drinkers as my friends."

At West Palm Beach, alcohol ruined his golf game; he took up boating. He was given to plying the waters of the Bahamas for days without being able to recall later where he had been.

That ended for him on May 8, 1983, when he took his last drink. His life was saved, he has no hesitation in saying now, by a physician friend who tricked him into attending an ostensibly open meeting that turned out to be closed. The meeting was about Dr. Summer's problem.

Unconvinced he had one, he nevertheless went to AA meetings over a period of several months, "sometimes drinking, sometimes not drinking," nursing his denial.

Something got through to him; he finally decided he did, in fact, have a problem. But he was not willing at first to face the lone and level sands of total sobriety. He would, instead, reduce his consumption, a common pitfall. He wanted to believe that having cut down from a fifth to three or four drinks a day, and going dry for a day or two now and then, proved he was in control. Finally, when his denials had run their course, he was forced to acknowledge his dependency.

"I didn't use drugs. Drugs take you down a long way and mess up your cognitive processes. I went to AA, every day, sometimes twice a day, for a year. The second year I went almost every day. The third year I was down to 150 meetings; I still attend a couple of meetings every week."



*Question: Does this really work — going to all those AA meetings? Or is it just some kind of persistent myth, a security blanket maybe?*

Answer: "It works, it really works, because you've got to make staying sober the first priority in your life, ahead of your business and your family, because if you slip you're going to lose your family and your business.

"Fortunately, I had an office that was close to a noon meeting. By that time, my office practice had gone down anyway. From 12 to 1, I went to AA. After that noon meeting, I would go home. I had two pre-teen daughters to look after when their mother was gone—nine months at one time. [Their mother, who had alcohol problems of her own, subsequently died. Dr. Summer married Andrea in 1987.]

"What works about AA is the mutual support and bonding—'If you can stay sober today, I can stay sober.'

"After a while, your physical health returns, in maybe two or three months. In about three or four months your attitude changes or begins to change. If that change of attitude doesn't occur, you're in trouble. And if you think you can do it alone, without AA, you're in even deeper trouble.

"That's the main reason I still go to AA, even though I work in the field, so I don't have any trouble. I never think about taking a drink any more.

"One of the things I've noticed about myself is that I no longer like to be with people who are drinking. After they've had a couple of drinks, I pick up on subtle little personality changes, and I don't care to talk to them."

*Q: What kind of time frame are we talking about in this type of recovery?*

A: "Of course it never ends. Every morning I ask God to keep me sober. At night I thank God for keeping me sober for that one day. It has become a habit — after almost nine years, a habit.

"It says in our AA *Big Book* (reaching into his nearby bookcase) there will come a time in every alcoholic's life when the strength to resist taking a drink must come from a higher power. (Here Dr. Summer turns to his lovely wife, Andrea [Andy, he calls her], and asks, "What page is that on, Honey?" "Page 42," she replies without hesitation. Andy is working on her Master's degree in psychology and is intensely interested in addiction.)

"It takes about three years before there occurs a

transition in the way you think, a kind of spiritual metamorphosis. By a spiritual attitude I mean you learn to approach life with tolerance, honesty, patience and understanding. It doesn't happen before two years. That's why I instituted a five-year recovery monitoring contract when I came here. Most states require that. You have to be sure the transition has occurred and that the physician is in a good recovery."

*Q: But isn't there some kind of epiphany before then, a time fairly early on when you become optimistic about the future, as if doors have suddenly been opened? Or does this kind of thing happen only in Hollywood while true recovery is slow and gradual?*

A: "It's slow and gradual." (Here Andy interjects, "There's the pink cloud.")

*Q: What about the pink cloud?*

A: "That's a superficial thing. In AA they talk about a time fairly early when you think the world is your oyster. It is a very dangerous time. I am seeing a doctor tonight, for example, who will probably tell me about his own pink cloud. And I will tell him he is in a very dangerous period."

*Q: Dangerous? Why?*

A: "Because the first thing that often happens in the so-called pink cloud period, which may come in eight or ten months after recovery has begun, is that they stop going to meetings. They don't feel the need. Then their brain starts whispering, 'I believe I could have a social drink, a little glass of wine maybe....'

*Q: Then the pink cloud is an illusion, a mirage?*

A: "Absolutely. And because it is, it is especially dangerous. Recovery is a slow process; there is no easier, softer way."

*Q: You have written that the addicted doctor is different from others in the general population. A lay person, like myself, might suggest this is just another example of professional snobbery. Would you explain how an impaired physician is different from, say, an impaired postman?*

A: "A doctor is different, in these ways: he or she

# FREEDOM FROM PAIN!

Extra strength pain relief  
free of extra prescribing  
restrictions.

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

## Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

## The heritage of VICODIN<sup>®</sup>,\* over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin ES** 

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

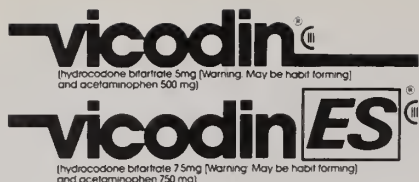
Tablet for tablet, the most potent analgesic you can phone in.

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knott Pharmaceuticals

2. Standard industry new prescription audit





**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

**WARNINGS:**

**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**PRECAUTIONS:**

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

**Use in Pregnancy:**

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:**

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

**DRUG ABUSE AND DEPENDENCE:**

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

**OVERDOSAGE:**

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

has a ready access to drugs; he has a deity position given to him by those around him, and which began in his medical training. In fact, a doctor in treatment will either promote himself to a godlike position in the facility or other patients will promote him to that position. Happens all the time.

"Doctors spend all their professional lives telling others how to live—bankers, lawyers, whatever. Doctors learn early to control their emotions. We are not supposed to be emotionally responsive to blood, guts and sex. Yet we have to be super-responsive to patients, to other doctors, to the eternal beeper, regardless of the situation.

"Doctors have a little more than average intelligence. They have a little more than average determination. They had to have these qualities to sit all those hours studying, taking exams and the rest. When they finish medical school, they have a lot of knowledge, knowledge that enables them to help their fellow man and to get more material good out of the world than most people.

"What medical school doesn't give us is wisdom. Wisdom comes from spiritual and emotional development, and these have their origin in the basic family value system.

"As time goes on, and if there is no outside influence, most doctors gather wisdom. But addiction to drugs or alcohol halts that process of emotional and spiritual maturity. Unfortunately, lots of doctors measure the success of their lives by the homes they live in, by the cars they drive, and whether they are president of the Chamber of Commerce.

"They can achieve all these things and still be alcoholics. But wisdom has passed them by. This is first evident in the home. If they don't recognize other people's feelings, homes turn into places of destruction. Divorce, family disruption, bankruptcy — all this can happen before there is any sign of professional impairment."

*Q: I would have thought professional impairment would come first.*

A: "No, work performance is the last thing to go in a doctor's life. He may lose his family, his home, everything he has acquired, before professional impairment is evident. There will be rumors and innuendo before his work begins to deteriorate. A doctor may have lost everything, but he's still making money, driving a Mercedes, and for a time he can delude himself into believing he's still on top. But that bubble is soon to burst because the one thing he



doesn't have and needs most is the one thing he can't buy—wisdom, spiritual and emotional maturity.”

“As a result of contact with physicians in the treatment center and the observation of physicians in the recovery process, my interest in physician impairment became greatly increased. I became associated with Florida's impaired physician program [Physicians Recovery Network—PRN] in September 1988.

“Since then, I have been involved in many interventions on impaired physicians, following them in various treatment programs and in post-treatment monitoring programs. Working with Florida's program director, Dr. Goetz, has shown me how effective a good program can be in the education of physicians and hospitals and in earlier intervention of impaired physician colleagues.

“I have had the satisfaction of seeing a number of severely impaired physicians return to being productive, happy and grateful individuals. As a result of this experience, I wanted to develop a state impaired physician program. And, being a ‘southern boy’ I wanted to try to find a southern state before looking north.”

*Q: All right, sir, now you have that opportunity. Could you outline your plans for the first year or so as the first full-time medical director of such a program in this state?*

A: “I'll do that, but first here is the philosophical premise that's the foundation of the plan for Alabama—

“The most effective treatment of addiction is the 12-step program orientation derived from Alcoholics Anonymous. Recovery from substance abuse, including alcohol, requires recognition of the problem and intervention followed by controlled detoxification from the chemical effects.

“In most cases this requires inpatient treatment and withdrawal from practice for an interval of time determined by the treatment providers. This time is necessary to break through the individual's denial system in order to begin to bring about the change in attitude so necessary to recovery.

“Other types of addiction, such as to food, gambling or sex, appear to be best treated through a 12-step program coupled with psychotherapy. Psychiatric illness, including bipolar disorder, may be associated with addiction to various substances.

“Now, you asked about plans for the first year. My priorities are evaluating the current status of the pro-

gram, and establishing a network for recognition and intervention, treatment, monitoring and family involvement for the impaired physician.

“The key to marketing is education through The Alabama M.D., Alabama Medicine as well as my personal presentations.

“Because family involvement is so important in recovery, I also plan to make full use of the Association's Auxiliary.

“If physicians in Alabama are similar to those in Florida, education in chemical dependency, including the need for early recognition and intervention, is much needed and is paramount to the success of the program. There is also a need to develop liaisons with the medical schools in developing chemical dependency programs for the medical students and faculty.

“The Florida experience suggests that hospital and medical society impaired physicians committees and the impaired physician's close peers are not as effective in recognition and intervention as an experienced program medical director. Therefore, I will do most interventions during the first year or so, until others are adequately trained.

“In addition, an ongoing regional monitoring network will need to be set up and closely supervised during the first year. This will insure that recovering physicians are not slipping through the cracks. This network will include approved group therapy, Caduceus meetings, state and national IDAA meetings, random body fluid monitoring and periodic reports to my office.

“I would like to underscore the vital importance of educating the Auxiliary in the absolute necessity of family involvement as crucial to the recovery process.

“As physicians recover, the program will begin to market itself, resulting in earlier detection of impairment and fewer consequences to the sick physician. In the future, as the program matures, I see a network so efficient that it could easily encompass other health care professionals.

“One of the outstanding characteristics of solid recovery is the desire to get involved. That is, recovering physicians reach out to help each other by their example.”

*Q: That's your own story, isn't it?*

A: “Yes it is.”

[See the following article by Dr. Summer outlining the Alabama program in more detail.]



# EIGHT GOOD REASONS TO SWITCH HEALTH INSURANCE COMPANIES

---

## 1 LOW RATES

*Compare our premiums to what you're paying now*

## 2 CHOICE OF DEDUCTIBLES WITHIN YOUR GROUP

*Mixing deductibles within your group can help control expenses*

## 3 PERSONAL SERVICE

*We're large enough to meet your needs - yet small enough to care*

## 4 A TRADITION OF TRUST

*We've been serving health care professionals exclusively since 1978*

## 5 AN A+ FOR FINANCIAL STRENGTH AND STABILITY

*Affiliated with Mutual Assurance, rated A+ by A.M. Best*

## 6 A CHOICE OF PROVIDERS

*Total freedom to choose the doctors you want to use*

## 7 RAPID CLAIMS HANDLING

*Most claims paid within two weeks*

## 8 NO PRE-CERTIFICATION REQUIRED

*No administrative headaches or hassles for you or your family*

IF YOU THINK THESE ARE GOOD REASONS  
CALL 1-800 344-9588

**LifeSouth**

PROFESSIONAL'S HEALTH PLAN

# Alabama Impaired Physicians Program

*Gerald L. Summer, M.D.*

*Medical Director, MASA Impaired Physicians Program*

Chemical dependency, psychiatric and personality disorders in the physician and other health care professionals are problems compounded by a conspiracy of silence, misunderstanding by peers and the association with many misconceptions about the disease.

Denial of the problem plays a prominent role in both the impaired physician and his or her colleagues. These unhealthy combinations frequently result in delayed diagnosis and treatment.

Chemical dependency, primarily to alcohol, is the type of impairment seen most frequently. The American Medical Association recognized alcoholism as a distinct disease entity in 1955. In 1990, the American Society of Addiction Medicine defined alcoholism as: "a primary chronic disease with genetic, psycho-social and environmental factors, influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking; preoccupation with the drug, alcohol; use of alcohol despite the adverse consequences; and distortion in thinking, most notably, denial." (Denial is an unconscious distortion of reality, as opposed to lying, which is a conscious distortion of the facts.)

Alcohol is the most commonly used chemical, but abuse of opiates, cocaine and various prescription drugs is frequent among health professionals. The frequency of this illness among health professionals varies widely, in the sparse available literature.

This problem is compounded by the various additional medical professionals employed in hospitals. Because impairment of just one physician could result in multiple medical complications and huge legal liability with adverse publicity, it is critical that all health providers be cognizant of this dilemma and the solutions available.

A common misconception is that impairment of the physician's duties must be proven prior to establishing a definitive diagnosis. Even when impairment is

obvious, associates are likely to delay confronting their impaired colleague. Frequently, job performance is the last to suffer from impairment or become apparent. When professional impairment becomes obvious, the disease process is already far advanced.

Personality change and family disruption, including divorce, are well known to occur prior to demonstrable impairment of professional duties. In many cases, the odor of alcohol on the breath of the professional at work indicates significantly advanced disease needing proper intervention and treatment.

Realizing that safety is paramount, a 1988 Alabama Law (88-536) enabled the Board of Medical Examiners to contract with MASA for the creation of an Alabama Impaired Physician Committee to promote early identification of physicians impaired by illness as a result of the use of chemicals or as a result of any physical or mental condition.

The legislation provided: in some cases, a therapeutic alternative to the disciplinary process; in other cases, therapeutic intervention and treatment concurrent with disciplinary action; recognition that illness and recovery are mitigating factors in Board disciplinary proceedings, and offers incentive for early interventions and treatment.

It also provides the licensee an opportunity to re-enter practice after completing treatment and progressing satisfactorily in recovery. The first full time Medical Director of the program was appointed October 1, 1991.

As a result of ready access to drugs, self-prescribing, and multiple other contributing factors, physicians are at high risk to progress to alcohol and drug abuse. When the dynamics of denial develop and professional responsibility is no longer safely recognized, significant impairment of performance is likely present.

Malignant denial in physicians dictates that they cannot ask for help for themselves. Colleagues have the misconception that someone else will take care of



the problem, or worse, that there is no problem at all. A failure to understand results in the fallacy that meddling in one's personal life is taboo.

Complacency or unwillingness to become involved may result in multiple consequences besides delayed diagnosis and treatment. It is recommended that early referral and subsequent evaluation be considered by any concerned colleague. The Alabama law (34-24-361 and 34-24-360), creating the Impaired Physician Program, states: Any physician or osteopath who in good faith makes a report to the Board of Medical Examiners shall not be liable to any person for any statement or opinion made in such a report.

There is a solution. Intervention is the presentation of reality to an individual in a manner that cannot be ignored through the individual's process of denial. Successful presentation is based on a totally honest, caring, believable and understanding approach, utilizing all the information available from concerned professional and nonprofessional peers as well as family members.

Difficulty deciding when to intervene occurs frequently with the inexperienced, even when the problem is obvious. A successful intervention demands experienced planning with predetermined alternatives and utilization of experienced professionals.

The Alabama Impaired Physicians Program is composed of professionals who are experienced in effective and confidential intervention. The program may be contacted by the physician seeking treatment, the hospital administrator, concerned family members or other individuals. All referrals are quietly and promptly evaluated, respecting the reputation and rights of the individual.

Each intervention is adapted to the individual needs of the vulnerable physician. The physician is informed of his or her vulnerability and is notified of

Alabama law that protects his or her license and confidentiality as long as he progresses in the system prescribed by the Alabama Impaired Physicians Program.

The Program will arrange for evaluation by an approved treatment provider and offer guidelines for the physician to re-enter practice. By calling (205) 263-6441 or 1-800-392-5668, the recovery process can begin.

In summary, the MASA Impaired Physician Program will provide:

- Immediate availability which shifts the burden of intervention from the reporting individual(s) to the program.
- Experienced and confidential interventions and treatment evaluation recommendations. Physician-staff conflict can be curtailed and patient safety enhanced as well as diminished malpractice suits and the avoidance of public record.
- Established guidelines for physician re-entry to medical practice. The program insures that the physician can be returned to a productive status in most cases.
- Discrete evaluation of each case and the protection of the anonymity of the physician and others associated whenever humanly possible.
- A contractual agreement between the physician and the program which lessens the occurrence of relapse and provides for early detection and management if relapse does occur.
- Education for hospital staff and other physician groups and assistance with organization and implementation of local impaired physician programs.
- Assistance to families of impaired physicians during the recovery process.



# Silence Is Not Golden

Is your malpractice carrier silent except when they want money? If you have questions, are you connected to someone who can answer them?

You *won't* get the silent treatment at ICA, and you *will* get answers from real people who care about you and your practice.

**Call Us,  
We'll Really Talk.**

From the CEO... to the President... to an Underwriter... to a Claims Attorney... we'll talk to you about the importance of the consent-to-settle clause, our tough stand on claims, risk management, and credits to reduce your premium, anything of interest to you.

**ICA**

Insurance Corporation of America  
4295 San Felipe P.O. Box 56308  
Houston, Texas 77256-6308  
1-(800)-899-2356 (713) 871-8100

**Defending Defensible Doctors**



# UAB Medical School Deans and Alabama Medicine

*Alston Callahan, M.D., F.A.C.S.\**

The dramatic advance of the four-year UAB Medical School from its inception in 1944-45 to its leadership position in the United States in 1991 is due to a number of fortunate coincidences. Perhaps the most important of these were the physicians and their associates who came together in Birmingham in those years. It is generally agreed that Joseph F. Volker, D.D.S., was the central genius who worked with, selected, and inspired a marvelous team so effective that even the premature and calamitous death of the first Dean of the Medical School, Roy R. Kracke, was overcome. This article deals only with the effect of the work of the Medical School Deans, omitting the great contributions of the Presidents and the University of Alabama Board of Trustees. As the reader will find, this article has been written objectively.

A phenomenal improvement in delivery of medical care to Alabamians and patients who have come to our state for health problems has been made by the UAB Medical School and its graduates.

## STUART GRAVES, M.D.

Tenure: 1928 - 1947

Dr. Stuart Graves served as Dean of the University of Louisville (Ky.) School of Medicine from 1922 to 1928. He was also the pathologist at the City Hospital of Louisville, Kentucky, and a member of the Medical Advisory Committee of the Kentucky State Board of Charities and Corrections.

In 1928, he accepted the appointment as Dean of

the (two-year) Medical College of Alabama at Tuscaloosa, and served for nineteen years until it became a four-year medical school. He was also the Professor of Pathology from 1928 until 1945. During the years 1929 -1930, he was the acting State Health Officer of Alabama. In 1937, he was awarded the L.L. Degree from the University of Alabama.

In 1944, Dr. Graves accepted the position of consultant in pathology at Northington General Hospital, a temporary U.S. Army Service Forces hospital of 2,000 beds, located in Tuscaloosa. With 300 beds for patients with eye injuries, this hospital was one of the five eye centers for the Army Service Forces in the USA. I was the Chief of the Eye Service, and Dr. Graves helped me with specimen tissue studies. It



---

\*The Eye Foundation Hospital, 1720 University Boulevard, Birmingham, Alabama 35233. Dr. Callahan, physician-founder of the Eye Foundation Hospital, is one of the very few Alabama physicians who personally knew and worked with (or tried to work with) every UAB Medical School Dean, beginning with Stuart Graves, who for nineteen years was the Dean of the two-year Medical School at Tuscaloosa, Alabama.

was also my good fortune to live next door to him in the Highlands, a residential section of Tuscaloosa.

Dr. Graves was greatly admired for his firm direction of the Medical School and for the excellence of the department chiefs he recruited. One of Dr. Graves's students was Dr. Edward Maumenee, who became the director of the Wilmer Institute of Johns Hopkins Medical School. Dr. Maumenee recalls that on the Tuscaloosa faculty were John Bruhn, the eminent physiologist, who served as the chief of that department, and Charles Goss, who headed the Anatomy Department and was selected to rewrite *Gray's Anatomy*.

Later, Dr. Goss became the Professor of Anatomy at the LSU Medical School. Another faculty member was George Pack, who became the director of the Sloan Kettering Cancer Institute in New York City. Some of these contacts he may have made through the Nu Sigma Nu Medical Fraternity of which he was the "aggressive" national Secretary-Treasurer. He was gratified that all of his graduates were quickly accepted into the junior class of long established institutions, as Cornell Medical School, Tulane Medical School, and the Johns Hopkins Medical School.

He was aware that once our physicians-to-be left the state, it was likely they would make contacts for locations of practice elsewhere and would be lost to Alabama. He enthusiastically promoted the idea of the four-year medical school.

## ROY R. KRACKE, M.D. Tenure 1944 - 1950

Dr. Roy Kracke, a native of Hartselle, Alabama, was the Professor of Pathology, Bacteriology and Laboratory Diagnosis at the School of Medicine, Emory University in Atlanta, Georgia. He was an illustrious hematologist, whose text, *Diseases of the Blood and Atlas of Hematology*, was used by physicians worldwide. Also, he edited the textbook, *Clinical Pathology*.

Dr. Kracke resigned his position at Emory to become the Dean of the newly organized four-year Medical School in Birmingham on Aug. 1, 1944. The Medical College of Alabama at Birmingham was then an organized extension of the University of Alabama at Tuscaloosa, and Dr. Kracke reported to Dr. Raymond R. Paty, President of the University. In turn,



Dr. Paty reported to the University of Alabama trustees.

The ferment around the Medical Center and Dr. Kracke was exciting in those early years — the Medical College activated in 1945, the Dental College in 1947, and the Nursing School shortly thereafter. Dr. Kracke had been appointed as Medical Advisor on Veterans Affairs by President Harry Truman, and he, with the help of Colonel William Pritchard of the American Legion, was successful in locating a Veterans Hospital facility diagonally across from the Jefferson-Hillman Hospital. The Quarterback Club of the Crippled Children's Foundation constructed the Crippled Children's Clinic for the treatment of polio victims directly across the street from the Jefferson Hospital. Now, at long last, a four-year medical education, with residencies and post-graduate study, was available in Alabama, and the exodus of outstanding medical men and women began to wane.

With the help of Senator Lister Hill, the first public health building in the United States financed by Hill-Burton funds was built in the Medical Center on 8th Avenue South and 20th Street. Frank E. Spain, Ehney



Camp Jr., Hugh Denman of the Birmingham Housing Authority, and Senator John Sparkman acquired 45 square blocks of land in downtown Birmingham for the Medical Center. In 1941, the Basic Science Building for the Dental and Medical College was completed.

Along with many triumphs and successes, some problems arose. Critics would call Dr. Paty in Tuscaloosa with complaints. He would reply that the Medical College and its Birmingham responsibilities were so complicated that he had to depend upon Dr. Kracke's decisions.

It was my good fortune to have met Dr. Kracke in Atlanta in 1941, just prior to World War II. I was the ophthalmologist at the Ponce de Leon Eye and Ear Infirmary, owned and operated by Dr. Murdock Equen, a close friend of Dr. Kracke. We three attended several Georgia Tech football games together.

In 1944-46, I was stationed at Tuscaloosa as Chief of the Eye Service of the Northington General Hospital, Army Service Forces. (Allocated to ophthalmology were 300 beds, 1,000 beds for plastic surgery, and 700 beds for supportive services as general surgery, orthopedics, urology, and psychiatry.) Dr. Kracke asked that I be given temporary leave from Tuscaloosa to lecture to the medical students on ophthalmology in Birmingham, which I did. When discharged from the Army my family and I moved to Birmingham and I served as the Chairman of the Department of Ophthalmology. My Medical College salary was \$12,000 a year, which I turned back to the School to employ an eye photographer. Dr. Kracke suggested to some other faculty members that they also turn in their salaries for better technical support for their departments; they did not care to do this. Several faculty members criticized me privately.

Knowing of my Army surgical experience, Dr. Kracke introduced me to Charles C. Thomas, who had published Dr. Kracke's texts. Mr. Thomas was shown the manuscript for my first book, *Surgery of the Eye-Injuries*. He requested that he be allowed to publish it, which he did. During this dinner meeting Mr. Thomas told us of the famous rare medical book collection of Dr. Lawrence Reynolds, a native Alabamian who directed a large radiological group in Detroit. We made plans to try to get this library for the Medical College of Alabama.

Dr. Kracke had an open-style office. When I brought a problem or a request to him and the matter was settled, he would suggest that I stay for a while as he conducted other matters.

One such time, Dr. Charles Goss, the Anatomy

Department Chairman, came rushing into his office, and with excitement showed Dr. Kracke a letter he had just received. Dr. Kracke motioned for me not to leave. The letter was an offer of the Chairmanship of the Department of Anatomy of the LSU Medical School in New Orleans. Because Dr. Goss was the then Editor of *Gray's Anatomy*, and was arguably our most prestigious faculty member, I expected Dr. Kracke to beg him to stay in Birmingham. To my astonishment, Dr. Kracke leapt from his chair, grasped Dr. Goss's hand, and congratulated him.

As Dr. Goss began to explain that he would prefer to stay in Birmingham, Dr. Kracke overruled him, saying that he had received a great honor, and because LSU was a more prestigious medical school, he, Dr. Kracke, would not stand in his way, and therefore accepted his resignation.

I was stunned. There was some argument because Dr. Goss really didn't want to leave, although he had unsuccessfully requested more time for teaching and more space for his department. Dr. Kracke smilingly waved him away and said, "We'll get somebody to pick up the pieces; Dr. Foley can do us a good job until we can find a permanent replacement. You let LSU know that you'll be there for the next term."

After Dr. Goss left his office, Dr. Kracke smiled and said, "His ego is too big for us, but will be just right for New Orleans."

In 1948, President Paty resigned from his position with the University of Alabama in Tuscaloosa to accept the Chancellorship of the Georgia University System. The University of Alabama Trustees asked Dr. John Gallilee, Dean of the Engineering School, to serve as Acting President of the University of Alabama until a permanent president could be appointed.

Dr. Kracke was an inspiring personality. In the short six years that he was Dean, his knowledge, diplomacy, appointment of staff, and sense of purpose gave the Medical School a wonderful impetus toward what it has now achieved in 1991. Because of the growing complexity of the various institutions in Birmingham, Dr. Kracke requested that the University trustees appoint, in addition to the Medical Dean, a Vice President for Medical Affairs. This was not done until several years later. He died suddenly of a heart attack in 1950, at the age of 52. Next to his family, I was one of those who felt his loss most keenly.

As related in the following biography, Dr. Gallilee appointed Dr. Tinsley Harrison as the Acting Dean of the Medical School.

TINSLEY HARRISON, M.D.  
Acting Dean 1950 - 1951

In 1950, Dr. Kracke persuaded Dr. Tinsley Harrison to move to Birmingham and accept the Chairmanship of the Department of Medicine. The seven years he served in this capacity were exciting and inspiring to the student body and the entire faculty. As mentioned earlier, upon Dr. Kracke's death, Acting President John Gallilee appointed Dr. Harrison as the Acting Dean of the Medical School, which appointment he thought would be for only six weeks. However, two years elapsed before the new dean was found, approved, and installed.

A year earlier, I had been pleased to receive an 80 year old patient, Dr. W. G. Harrison. His grandfather had been an Alabama physician, and his son was the famous Tinsley R. Harrison, the Professor and Chairman of the Department of Medicine at Southwestern Medical School in Dallas. The Montgomery physician who referred Dr. W. G. Harrison said over the long distance phone that since Dr. Harrison's sight was almost out that he was ready for me to remove his cataracts.

Dr. Harrison could not see the eye chart, nor count my fingers held in front of his eyes; he could barely discern light. His eyes were neither red nor painful. When I examined his eyes with a slit lamp microscope, it greatly concerned me that his crystalline lenses were clear and that he had no cataracts. Examination through his pupils with the ophthalmoscope brought the shocking knowledge that his optic nerves were deeply cupped, white, and atrophic. The retinal blood vessels were curved sharply over the edges of his optic discs. It was no surprise then, to find that the ocular pressure of the right eye was 45 mmHg, the left, 52 mmHg. Obviously, the referring physician had not tested his ocular pressure and had missed the diagnosis of chronic glaucoma. Dr. Harrison asked when could I remove his cataracts.

After a few moments of thought, I decided to call his son in Dallas. It had been rumored that Dr. Tinsley Harrison had been invited to accept the Chairmanship of the Department of Medicine at the Medical College of Alabama. It was possible to get him on the phone in Dallas within a few moments, and I told him the sad story. Dr. Harrison asked if surgery would not help him "just a little bit." I regretfully replied in the negative, and said that the pressure could probably be lowered with antiglaucoma eye drops which I would prescribe, but as he must know, it would be impossi-



ble to restore or regain any sight whatever. Naturally, Dr. Harrison was upset. He told me he would be coming to Birmingham soon and would see his father and me when he came. Later, he engaged a medical student to look after his parents, and located them conveniently in an apartment complex nearby. It was a catastrophe; Dr. W. G. Harrison was blind.

Tinsley was an internationally recognized internist with a special interest in cardiology and the editor of one of the most famous textbooks in medical literature, *Principles of Internal Medicine*. The first and second editions were published in Dallas, but the third, fourth, and fifth were improved and enhanced by him in Birmingham.

After his death, other distinguished editors took it over, and it is now in its nineteenth edition, a constantly improved memorial to him.

As Acting Dean, Tinsley was most effective. He continually inspired students and faculty alike. He was forthright, not always diplomatic, and unafraid to take an unpopular position when he felt certain that he was in the right.

Tinsley chose me as his personal ophthalmologist, and from time to time it was necessary to change the power of his spectacle lenses. In 1977, he began to lose his coordination and judgement of distance.



Although his visual acuity qualified him for a driver's license, his family and his family physician requested that I be the one to tell him he could no longer drive a car. When I did so, he became angry and accused me of "ingratitude." When I continued to refuse, he tried to get our son and his former student, Dr. Michael A. Callahan, to consent. Mike sadly declined, also.

He contributed greatly to the UAB Medical School by recruiting outstanding faculty members—Drs. S. Richardson Hill, James A. Pittman Jr., Ben Branscomb, and Walter Frommeyer, who were to be the leaders of the Medical School for the next decades. The UAB School of Medicine was advanced greatly nationally and internationally by his efforts.

### JAMES J. DURRETT, M.D. Tenure 1951 - 1955

Prior to his return to Alabama, Dr. James J. Durrett was the director of the Food and Drug Administration in Washington, D. C. He was a University of Alabama graduate and a member of a highly respected Tuscaloosa family. Dr. Gallilee, with the concurrence of the University trustees, appointed Dr. Durrett as Dean of the Medical School. He had no other title, but actually he acted as the Vice President for Health



Affairs in Birmingham. This allowed Dr. Harrison to return to his responsibilities as chief of the Department of Medicine. Dr. Gallilee had the utmost confidence in Dr. Durrett.

One of Dr. Durrett's greatest goals was the acquisition of the rare medical book library of Dr. Lawrence Reynolds. As mentioned earlier, Dr. Reynolds, an Alabama native, headed a large radiological group in Detroit, which had the responsibility of the radiological service for most of the Detroit hospitals. Also, Dr. Reynolds edited the *American Journal of Radiology*, published by Charles C. Thomas. Unmarried, Dr. Reynolds had used his income to purchase many rare medical books. Dr. Durrett asked me to help get the library for the Medical College, as I was Dr. Reynolds's friend and had entertained him on several occasions at The Club.

We knew that Yale University and Wayne University of Detroit were making energetic efforts to persuade Dr. Reynolds to give his library to them. It was gratifying that he selected me to be his ophthalmologist, even though he was a diabetic without good dietary self-discipline. He developed diabetic cataracts, which I removed in 1957 and 1958, and he enjoyed good vision until his death in 1961.

On Saturday, March 22, 1952, Dr. Durrett asked me to arrange a luncheon for Dr. Reynolds at the Mountain Brook Country Club. Other guests were Dr. Oliver Carmichael, Dr. Durrett, Dr. James S. McLester, Dr. Seale Harris, Dr. Howard Holley, Dr. James Crenshaw, Dr. Champ Lyons, and Dr. Richard Bing. As I drove Dr. Reynolds from his hotel to the luncheon, he excitedly told me that he had decided to give his library to the Medical College of Alabama.

Most of the other guests had already arrived before us. As we were being seated, Drs. McLester, Harris, and Durrett each asked that they be called upon to request that he give his library to our Medical School. Instead, I asked Dr. Reynolds if he had an announcement to make. We cheered when he committed the library to UAB.

Although Dr. Durrett made no claims to be a medical educator, he was a strong, positive man and justified the confidence Dr. Gallilee had in him as the winds of circumstance blew back and forth while Birmingham tried to adjust itself to having a great Medical Center in its midst.

He was imperturbable when, in the spring of 1953, the Birmingham Fire Marshall took him to Recorder's Court for allowing trash and combustibles to accumulate on the 14th floor of the University Hospital. Dr. Durrett ordered the maintenance crew to remove the

offending materials and watched it being done. *The Birmingham News* ran a story about it, and when asked about the incident, he howled with laughter. "In a few more years," he predicted, "the City will realize just how important this institution is to it."

One Saturday afternoon in 1954, Dr. Durrett fell on the steps to the second floor of his home on Altamont Road, lacerating his face. Instead of calling any one of the UAB surgeons who would have been pleased to drop everything and attend to his wounds, he chose instead to "test the system" and went to the University Hospital emergency room, registering as J. J. Durrett, omitting his M.D.

For over two hours, he sat there calmly watching the action, no one recognizing him until by chance Dr. Champ Lyons walked by to attend a patient with a crushed chest. Later, Dr. Durrett assigned more personnel to the emergency room, but because of the high volume of serious injuries, the University Hospital emergency room always requires a large staff and extra efforts, especially on Friday and Saturday nights.

As Dr. Paty had said when questions were raised about Dr. Kracke, so did Dr. Gallilee reply to questions that Dr. Durrett was in charge of the Birmingham operations of the University.

In 1953, the University trustees thanked Acting President Dr. Gallilee for his services and appointed Dr. Oliver C. Carmichael as President of the University of Alabama, with the responsibility of overseeing the Tuscaloosa, Birmingham, and Huntsville campuses.

### ROBERT BERSON, M.D. Tenure 1955 -1962

When Dr. Oliver C. Carmichael became the President it soon became obvious that he lacked the confidence in Dean Durrett that Dr. Gallilee had had, and in 1955 he retired Dr. Durrett on Dr. Durrett's 65th birthday. To succeed him, he appointed Dr. Robert Berson as Dean of the Medical College. As for the Eye Foundation Hospital, Dr. Berson was firmly opposed to any independent hospital in the University Center that was not part of the University system.

In 1956 and '57, many problems arose with racial integration at the University of Alabama in Tuscaloosa, and Dr. Carmichael resigned from the

Presidency in 1957. The Board of Trustees appointed Dr. Frank A. Rose as the President of the University in 1958, in which position he served most ably.

In 1962, I asked Dr. Berson if the Eye Foundation, Inc. could purchase the quarter-block of land adjacent to and north of the Eye Foundation Hospital's quarter-block. When he refused, I insisted that he mention this request to the University of Alabama trustees at their next meeting. He did so, recommending against it. Thereupon, Ehney Camp Jr., the trustee from the Fifth Congressional District, remonstrated, saying that he favored its sale because it would be good for both parties.

When Frank Spain learned of Dr. Berson's opposition, he visited Dr. Frank Rose in Tuscaloosa, and complained that Dr. Berson was not a "good neighbor." What effect that had, or other problems Dr. Berson had, I do not know, but when Dr. Rose learned of a Texas medical school's search for a dean, he recommended Dr. Berson for the post, which he accepted.

About 1969, Dr. Rose and the University of Alabama trustees appointed Dr. Joseph Volker as the Vice President in Charge of Health Affairs and Dr. S. Richardson Hill as the Dean of the Medical School. Also, Dr. Volker was to report directly to the trustees rather than to the Tuscaloosa Administration.

On Dec. 16, 1966, the trustees of the University of Alabama sold the quarter-block of land to the Eye Foundation trustees for the sum they had paid for it, plus 6% interest, during the time they had owned it. We paid \$128,500.

### S. RICHARDSON HILL, M.D. Tenure 1962 - 1968

In December of 1955, Dr. Tinsley R. Harrison brought Dr. Hill to Birmingham from the Harvard School of Medicine and the Peter Bent Brigham Hospital. He had written two chapters in Tinsley Harrison's *Principles of Internal Medicine* at the request of his chief at Harvard, Dr. George W. Thorn. Dr. Harrison had taught Dr. Hill at another school of medicine, which he helped found—the Bowman Gray School of Medicine—and Dr. Harrison persuaded him to serve as a UAB Professor of Medicine and to direct the Division of Metabolism and Endocrinology.

Then in 1962, Dr. Frank Rose, the President of the University of Alabama, and Dr. Joseph Volker, Vice





President in Charge of Health Affairs in Birmingham, appointed him as the Dean of the School of Medicine. Dr. Hill immediately undertook the task of reorganizing the faculty of the Medical College of Alabama, the staff of the University of Alabama Hospitals and Clinic, the student body of the Medical School, and the Medical Alumni Association. He initiated a number of grant requests, including one for a general clinical research center, another for a medical rehabilitation research and training center, and still yet another for a major expansion of the student body. This immediately doubled the size of the student body of the Medical College.

Dr. Hill required that all graduates from the Medical College of Alabama must undergo the rigorous testing of the National Board of Medical Examination. Although the students objected to this requirement, they increased the average scores on their tests of students from the Medical College of Alabama from the lower to the upper third of the United States, and the students recognized the merit of this requirement and were proud of their achievements.

Dr. Hill recruited Dr. John Kirklin as Chairman of the Department of Surgery, Dr. Claude Bennett to become a faculty member and subsequently the Chairman of the Department of Microbiology and then the Chairman of the Department of Medicine,

and Dr. James Pittman, who replaced Dr. Hill as Director of the Division of Endocrinology.

While he was Dean, Dr. Hill initiated the planning of Volker Hall, the Lister Hill Library of the Health Sciences, the Spain Tower, and the Quarterback Tower of the Alabama Heart Hospital, the Wallace Tower, and the Tumor Institute Tower of the Lurleen B. Wallace Memorial Hospital and Tumor Institute. As Vice President (1968 - 1977) and then President (1977 - 1987) of UAB, he carried them on to completion.

## CLIFTON K. MEADOR, M.D. Tenure 1968 - 1973

Dr. Clifton Meador, a native of Selma, Alabama and a Markle Scholar, was recruited by Dean S. Richardson Hill in 1952 as an Assistant Professor of Medicine to develop a clinical research center. After the center opened on the third floor of the University Hospital, offering a place for clinical research of the faculty, Dr. Meador assembled a grant which made possible the complete renovation of the third floor of the Kracke Building (formerly the Hillman Nurses Home) for a laboratory to support clinical research.



After he became the Dean, he noticed that medical practitioners throughout Alabama had difficulty in contacting the physicians in the Medical Center. He set out to develop a telephone answering system and arranged for the faculty members to carry beepers, and the State Board of Censors approved the initiation of the telephone information system, first in four counties and then in all counties of Alabama. The MIST telephone service, which is still improving and expanding, is the contribution to Alabama in which Dr. Meador takes the greatest pride.

He spent considerable time traveling over Alabama developing friendships with the practitioners. His attempt to form a family practice department failed because, at that time, the specialists opposed the idea. This was his major disappointment, but he put on a number of continuing education courses in Birmingham that were attractive to the practicing physicians.

He spearheaded the preparation of grants and proposals for the Lurleen Wallace Cancer Center, the Heart Tower, and expansions of the University Hospital, and worked with the architects to build those structures adjacent to the Diabetes Hospital across the street from the University Hospital.

When Dr. Meador became the Dean, the Eye Foundation trustees had a new supporter. His uncle, Dr. Sam Kirkpatrick Sr. of Selma, had been an Eye Foundation trustee. My first official contact with Dr. Meador occurred in 1971, when the Eye Foundation acquired the third Kelman cataract phacoemulsifier ever constructed. This instrument was to change the course of ophthalmic surgery forever, because it reduced hospitalization for cataract extraction from a week to one day (and eventually to just several hours).

This was made possible due to the small incision in the eye, and even more importantly, because of the new technique the eye regained good vision in a few days, instead of several months. (Successful lens implants within the eye were not perfected until ten years later.) I advised Dean Meador that there were only a few such instruments yet available; they were expensive, and it was unlikely there would be another one in Birmingham for a year or two. Our trustees and medical staff had agreed that all board certified ophthalmologists of the Birmingham area who would qualify by taking Dr. Kelman's instruction course on how to use this new modality were welcome to bring their patients to the Eye Foundation and use it. Dr. Meador was gratified and advised the members of his ophthalmology department of our offer.

Then, he began to confer with me about his desire to combine the UAB ophthalmic residency training program with ours. He pointed out that if we joined our teaching programs and our resident staffs were organized as a unit, we could help more indigent patients. In turn, the residents would be taught by a larger faculty with more resources, and as we moved into eye research projects, the University's Basic Science Departments, Ph.D.s could work with our M.D.s and the Eye Foundation could receive NIH grants more readily.

So, in 1971, Dr. Meador appeared before the Eye Foundation Board, requesting that we join together. I thought we should forget the unfair deeds of some of the UAB officials in the past, because united we could achieve more than we could separately. The majority, but not all, of the Eye Foundation trustees agreed, and we did combine the two programs, which has benefitted all concerned. Together, Dr. Meador and I selected a Chairman for the Department of Ophthalmology, and the teamwork that began then has continued to the present time.

Dr. Meador's father was a veterinarian, and he began working with the officials at Auburn University to educate farmers and others at the local level in preventive health measures for animals. Dr. Meador began a program with Auburn University whereby the Extension Service would help in human preventive measures and human health education measures at four sites in the state, but he left Alabama before this could be accomplished.

In 1972, Dr. Meador decided to resign the UAB Medical Deanship to accept a position on the faculty of Vanderbilt Medical School as Medical Director of St. Thomas Hospital in Nashville, Tennessee. We greatly regretted his departure.

## JAMES A. PITTMAN JR., M.D. Tenure: 1973 -1992

Dr. James A. Pittman Jr. first came to UAB as a resident in medicine under Dr. Tinsley Harrison in 1956. In 1968, he became the Chief of Medicine at the Veterans Hospital, which position he held for three years. When Dr. Clifton Meador resigned to accept a professorship in medicine at Vanderbilt University, Dr. Pittman was appointed as Dean of the UAB Medical School by Dr. Joseph Volker, President, and Dr. S. Richardson Hill, Vice President in Charge





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association



of Health Affairs.

His improvements in the Medical School organization include his restoration of the four-year curriculum, replacing the thirty-five month schedule that existed until 1973. Thereby, time was left free during summers to perform clinical work in rural areas, or to become involved with research projects. Prior to 1974, UAB medical students were evaluated with either a "pass" or a "fail" for their courses. He restored letter grades, much to the chagrin of the students. However, this system gave much better insight into each student's depth of understanding of subjects that physicians must learn.

He re-established basic medical science courses in anatomy, biochemistry, physiology, and pharmacology. Also, his efforts have resulted in the acceptance of out-of-state applicants with very high scholastic records. He funded the program to financially help students who wish to receive a doctorate of philosophy degree in addition to their medical degree. With the help of Associate Dean for Operations, he established a Medical Student Endowment for those students whose finances were limited. The total number of medical students enrolled in his first year of tenure was 480; in 1991 there are 660 medical students. The increase in the number of residents is even more dramatic.

Dr. Pittman has shown great skill in recruiting the

highest quality of individuals for faculty positions with his dedication to UAB, his pleasant affability, and his almost encyclopedic knowledge of the various medical disciplines. With the help of his widespread friends and associates all over the world, he has been most successful in persuading talented physicians to make Birmingham their home. Because of these assets and his extraordinarily long career as Dean, he has recruited and set in place all of the current Department Chairmen; their recognized abilities are responsible in large part for UAB's extremely high national rating.

Among Dr. Pittman's outstanding contributions was his concept and the construction of the Center for Advanced Medical Studies, made possible by a grant from Hall W. Thompson. The Center inspires and helps the academically superior, ambitious, dedicated, and gifted students and faculty members toward greater achievements. The Alpha Omega Alpha Medical School Academic Honorary Society is based in this building, and it is also the meeting place for the Medical Student Research Society, and the Tinsley R. Harrison Medical Student Society, the latter two being organized by Dr. Pittman. This building is the forum for the presentation of the Doris F. Tulcin Award for best research in cystic fibrosis and numerous other official functions of the Medical School.

With Dr. Pittman's inspiration and encouragement, the Alabama Medical Alumni Association became an independent entity and was approved by the IRS as a 501(c)(3) organization. Invigorated with a "home" of its own, this association strengthened the ties between the UAB graduates and their alma mater with time, energy, and financial gifts made possible by the alumni. Its annual meeting is a highlight of the Medical School year.

Because of the unique relationship between the UAB Medical School and the Eye Foundation Hospital, and the need for frequent transfer of information between the Eye Foundation and the Department of Ophthalmology, the Joint Committee of Ophthalmology was created. The chairman of this committee is the Chairman of the Department of Ophthalmology; the committee consists of the Dean of the Medical School, the Associate Dean for Operations, the Chairman and the President of the Board of Trustees of the Eye Foundation. Meetings are usually held every two months for policy planning, budget considerations, research reports, and personnel changes. For the Eye Foundation, Dr. Pittman has been a wise counselor and an innovative advisor.

Another of Dr. Pittman's lasting contributions was





Sculpture of Dr. Tinsley R. Harrison by Cordry Parker at the entrance of Harrison Tower on University Boulevard.

his concept and completion of the publication of artist Max Heldman's book, *The First Forty Years of UAB*. In his 99th year, Mr. Heldman, a highly acclaimed artist, finished his sketches of the developers and leaders of UAB and associated institutions. Dr. Pittman selected the individuals and contributed the text. Shortly before Mr. Heldman's death, he autographed many copies of this valuable reference book which continues to enjoy a wide circulation.

With Basil Hirschowitz, M.D. and Edwin Rutsky, M.D., Dr. Pittman instigated and developed the UAB-Israel Medical Exchange Program so that outstanding physicians are exchanged between UAB and all of the medical schools in Israel.

Finally, and most importantly, his primary medical research interest is in thyroid physiology and disease. He hypothesized the existence of hypothalamic hypothyroidism, and in 1970 discovered a patient with this condition, which he reported in 1971 in *The New England Journal of Medicine*. He has made a number of important discoveries in this field.

In October 1991, having served as Dean for twenty years (the longest tenure a dean has served in modern times), he announced that he would resign from the Deanship in June 1992 and return to his true love, diagnosing and treating thyroid patients. His faculty, his students, and his many admirers cheer him for his decision to yet be of service to medicine.

Ms. Sandy Blackwood assisted with the editing and typing. John Bishop of the Eye Foundation Hospital Photography Department and Marion McGuinn of the Reynolds Historical Library furnished the photographs. I am indebted to them and the secretaries of Dr. Volker, Dr. Hill, Dr. Meador, and Dr. Pittman for their help in establishing the accuracy of this text.


## ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

FP, IM, GP needed in rural South AL flourishing practice. Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

FPs and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

ER PHYSICIANS NEEDED for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

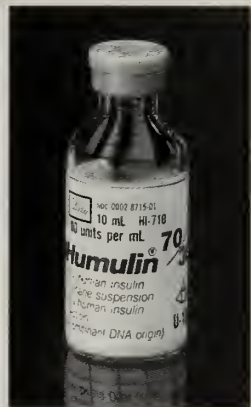


For your insulin-mixing  
or NPH-using patients

## Humulin<sup>70/30</sup> makes life easier

**Rapid onset and sustained  
duration insulin activity  
in a single vial**

- May offer enhanced control through a more physiologic activity profile
- Accurate dosing—eliminates mixing errors
- Convenient premixed dose for better compliance
- Easy to use—for patients who find mixing difficult



**Specify**  
**Humulin<sup>70/30</sup>**  
70% human insulin  
isophane suspension  
30% human insulin injection  
(recombinant DNA origin)

**Humulin has  
just the right mix**

Any change of insulin should be made cautiously and only under medical supervision.

Changes in refinement, purity, strength, brand (manufacturer), type (regular, NPH, Lente®, etc), species (beef, pork, beef-pork, human), and/or method of manufacture (recombinant DNA versus animal-source insulin) may result in the need for a change in dosage

*Leadership In Diabetes Care*



**Eli Lilly and Company**  
Indianapolis, Indiana  
46285



## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by

William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992

Above rates are provided by Jackson National Life

# Turtle Mountain Chippewas

*Wm. Harold Avant, M.D.\**

Nothing chronicles the adventures of man more than the offspring he leaves behind. This is what fascinated me about this tribe of Chippewas. Their names, Landry, Bougeois, Herbert, Olsen, and Johnson are French and Norwegian. The Norwegians came there to homestead and the French were trappers. The Norwegians stayed and the French said "hello, wham bam, goodbye" and moved on. Turtle Mountain is in the north central portion of North Dakota just below the Canadian border. The French were from Canada (Acadians) and the Norwegians were from the east coast.

It is really unusual to see blonde and blue eyed Indians. There are no full-blooded Indians among this tribe of twenty nine hundred people. This tribe receives all the subsidies that any other tribe does.

They differ from the other tribes of Indians in that they are very independent. One of the reasons is that they have a work ethic that differs from other tribes. I have worked with the Sioux and Crow and I found the Chippewas to be exceptional.

I worked in their medical facility for two weeks doing clinic work and minor surgery. This reservation is located in the northwestern part of North Dakota close to Fort Union. This is where the Missouri and the Yellowstone rivers merge and was a stop-off point of the Lewis and Clark Expedition. Fort Union was later controlled by John Jacob Astor. He used the fort to buy and protect furs he received from the trappers in that area. He was able to completely monopolize fur trading and made millions from it.

After tracing the route of the Lewis and Clark expedition for a few miles I was amazed at the difficulties they had to overcome. The trip to the moon

pales into insignificance compared to the two thousand miles of pushing, pulling, and paddling keelboats up the Missouri and Yellowstone rivers, and then going through the badlands to the Snake and Columbia rivers.

Before leaving the villages of North Dakota they hired a French interpreter by the name of Toussaint Charbonneau. He brought his wife Sacagawea and their son Jean Baptiste.

Sacagawea became famous as their cook, guide, scout, and nurse. They were approached by many tribes of Indians, more out of curiosity than hostility. Between the twenty one bales of presents they brought for the Indians and Sacagawea, they had little trouble with the Indians.

The original name of the Chippewa was OJIBWA, which meant "to roast until puckered up." The appellation Chippewa was officially adopted by the Bureau of American Ethnology, and actually is a corruption of Ojibwa.

This tribe of Indians suffers from the problems common to other tribes. These are alcoholism, trauma, infectious disease, and diabetes. A large number also have gallstones. This was a very satisfying experience for me and I plan to go back if called. Practising medicine where you are really needed is very gratifying.

I recommend Project USA to those that have an interest in American history and would like to give of their time and skills. There is also a mild culture shock when you are placed in the middle of a tribe of Indians.

My thanks to John Naughton of the AMA who arranged this trip through Project USA.

Historical data source: *Exploring The American West* 1982 Produced by the National Park Service of the Dept. of Interior.

\*20 Croydon Road, Mobile, AL 36608.



# The Alabama Impaired Physicians Program

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ♦ *Intervention*
- ♦ *Education*
- ♦ *Guidence to hospital, staff and employees*
- ♦ *Recovery monitoring*
- ♦ *Structured support groups*
- ♦ *Family assistance*
- ♦ *Advocacy*
- ♦ *Liason*
- ♦ *Quality Assurance*
- ♦ *Confidentiality*

***For information call: 1-800-392-5668 or 205-263-6441***

***On weekends, after office hours and holidays***

***call: 1-205-271-5759***

# Newly Licensed Doctors

Goitz, Henry Thomas, M.D.  
American Sports Medicine Institute  
P. O. Box 550039  
Birmingham, AL 35205

Ahn, Duke, M.D.  
1813 6th Avenue South, MEB 502  
Birmingham, AL 35233

Araneta, Maria Mercedes, M.D.  
Selma Pathology Lab  
311 Dallas Avenue  
Selma, AL 36701

Baggett, James Camp, Jr., M.D.  
P.O. Box 561  
Family Practice/Psychiatry  
Magnolia Springs, AL 36555

Beuttler, William Allison, M.D.  
1256 Brunswick Lane  
Department Anesthesiology  
Ventura, CA 93001

Bouffard, John-Paul, M.D.  
3836 Berkshire Drive  
Montgomery, AL 36109

Caputo, Robert Scott, M.D.  
4371 La Mirage Drive  
Pensacola, FL 32504

Chamberlain, Donald Heaston, M.D.  
2019 Pointe Clear Drive  
Biloxi, MS 39531

Dutt, Anil Kumar, M.D.  
Noble Army Hospital  
Department Surgery  
Ft. McClellan, AL 36205

Gladson, Candace Lynn, M.D.  
UAB /Department Neuropathology  
701 South 19th Street, Room 573 LHR  
Birmingham, AL 35294

Hardin, William Downer, Jr., M.D.  
1600 7th Avenue South, Suite 160  
Department Pediatric Surgery  
Birmingham, AL 35233

Harris, Calvin Jerome, M.D.  
4101-073 Shoreline Circle  
Department Psychiatry  
Virginia Beach, VA 23452

Henderson, Keith Francis, D.O.  
Southeast Alabama Medical Center  
US Highway 84 East @ Ross Clark Circle  
Dothan, AL 36301

Joshi, Harshvadan Pradyumn, M.D.  
Phenix Medical Park Hospital  
1707 21st Avenue  
Phenix City, AL 36767

Kalenian, Mark Hagop, M.D.  
Lyster Army Hospital  
Department Internal Medicine  
Ft. Rucker, AL 36362

Kamal, Toheed Jan, M.D.  
Lamar Regional Hospital /Internal Medicine  
P.O. Box 1289  
Vernon, AL 35592

Levine, Marc M., M.D.  
Medical Center East  
Department Emergency Medicine  
50 Medical Park East Drive  
Birmingham, AL 34235

Lieurance, Richard Coleman, M.D.  
216 East Battle Street  
Department Ophthalmology  
Talladega, AL 35160

Lilly, Raymond Lindsay, Jr., M.D.  
118 Ironweed Drive  
Dept. Neurological Surgery  
Pueblo, CO 81001



Liu, Ming Wei, M.D.  
UAB/310 Lyons Harrison Research Bldg.  
UAB Station  
Birmingham, AL 35294

Nichols, Raymond Lee, Jr., M.D.  
Florence Clinic  
416 North Seminary  
Florence, AL 35630

Peltier, Henry Matthew, M.D.  
Children's Hospital/Pediatrics  
1600 7th Avenue South  
Birmingham, AL 35233

Pflugrath, Ann Marie, M.D.  
725 Airport Road, Suite 300  
Department Anesthesiology  
Chapel Hill, NC 27514

Raquib, Farouk Anwarul, M.D.  
Lamar Regional Hospital/Family Medicine  
507 Fifth Street, SW  
Vernon, AL 35592

Reinecke, Mark Edwin, M.D.  
6710 Tanglewood Drive, NE  
Department Internal Medicine/Pulmonary  
St. Petersburg, FL 33702

Silver, Frederick Michael, M.D.  
USAMC/Rm 719 Mastin Building  
2451 Fillingim Street  
Mobile, AL 36617

Soto-Aguilar, Maria Cristina, M.D.  
USAMC/Dept. Internal Medicine  
2451 Fillingim Street  
Mobile, AL 36617

Steel, John Robert, M.D.  
Mobile Infirmary Medical Center  
Department Radiation Oncology  
P. O. Box 2144  
Mobile, AL 36652

Stick, Michael O., M.D.  
2047 Vestavia Park Court

Department Surgery, Emergency Room  
Birmingham, AL 35216

Sturdevant, Marsha Sue, M.D.  
UAB/Adolescent Medicine-Pediatrics  
UAB Station, CHT 157  
Birmingham, AL 35233

Teague, Stephen Michael, M.D.  
1717 North E Street, Suite 503  
Department Internal Medicine/Cardiology  
Pensacola, FL 32501

Turnage, Jimmy Wayne, M.D.  
17292 Perdido Key Drive, Unit T  
Pensacola, FL 32507

Wood, Michael David, M.D.  
USA MEDDAC  
Department Ob-Gyn  
Ft. McClellan, AL 36205

Jeffrey, Brett Edward, D.O.  
7833 2nd Avenue South  
Birmingham AL 35206

Nortick, Adam Ross, M.D.  
801-03 Noble Street, Suite 700  
Anniston, AL 36201

Macready, Kevin Michael, M.D.  
619 Idlewild Circle, #6  
Birmingham, AL 35205

Ronco, Ricardo Arnoldo, M.D.  
819 15th Street South  
Dept. Pediatric Intensive Care  
Birmingham, AL 35205

Von Oldenburg, Albert E., M.D.  
Greil Memorial Hospital  
2140 Upper Wetumpka Road  
Montgomery, AL 36107

Chong, Felipe, M.D.  
UAB /326 Lyons Harrison Research Bldg.  
UAB Station, Division Cardiology  
Birmingham AL 35294

# Your Telephone System May Have a Surprise in Store for You.



Ask yourself these questions, if you want to prevent costly problems.

- **Is your telephone system four or more years old?**

If so, let us show you how prices have come down since then. You may be in an advantageous position to trade, especially when you consider the increased costs of maintaining an aging telephone system.

- **Do you spend more than \$500 a month on telephone services?**

If you do, we'd like to audit your expenses to make sure billing is accurate and costs are in line. There may be several ways to save.

- **Are you planning to move your telephone equipment in the next six months?**

If you are, let us give you a free comparison on moving your equipment or trading it in on a new system with a two-year warranty.

- **Can your present system be modified to handle more calls?**

Very likely. There are new message handling and routing services that could make your system much more productive, without adding to your equipment cost.

- **Did you know there are new rate structures available for business telephone service?**

Absolutely. We'd be glad to discuss them with you to see if any new rates would be good for your business.

Because your business is on the line, call COMTEX today for a free, comprehensive telephone system check.

 **COMTEX**  
INTERNATIONAL  
*A Total Communications Company*  
Birmingham • (205) 871-3000  
Montgomery • (205) 271-4000



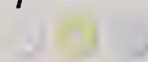
Your Rx for  
**Valium**  
(brand of diazepam/Roche)



may be open to  
seventeen  
interpretations...

unless you settle the issue by signing  
on the "Dispense as Written" line.

**VALIUM**<sup>®</sup>  
brand of  
diazepam/Roche<sup>®</sup>



2-mg 5-mg 10-mg  
scored tablets

*The final choice should really be yours*

The cut out "V" design is a registered trademark of Roche Products Inc.  
Copyright © 1991 by Roche Products Inc. All rights reserved.

**ROCHE** Roche Products  
Roche Products Inc.  
Manati, Puerto Rico 00701

\*According to the Orange Book, 10th ed, US Department of Health  
and Human Services, 1990, diazepam tablets may be available from as many  
as 17 companies. Tablets shown represent 5 mg diazepam tablets.



January 1992

Vol. 61, No. 7

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

MAR 30 1992

And whosoever shall  
compel thee to go a mile,  
go with him twain.

pg. 8

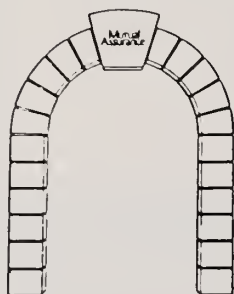


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 7, JANUARY 1992

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1992 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Myers, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Joel C. Pittard, M.D. (1992), Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

## EXECUTIVE DIRECTOR

S. Lon Corner

Secretary-Treasurer - Emmett Wyatt

## DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

*Physicians Are Different*.....2  
Gerald L. Summer, M.D.

Executive Director.....4  
*Killing the Golden Goose*

President's Page.....8  
*... And Then Some*

*Hospitalized Tornado Victims*.....12  
LeRoy F. Harris, M.D.

Newly Licensed Doctors.....21

Classifieds.....26

Auxiliary.....28  
*Dr. James Grotting and Operation Smile*

*Charge*.....30  
Harold Avant, M.D.



# Physicians Are Different

*Gerald L. Summer, M.D.\**

Having recently completed 22 years in the private group practice of Internal Medicine and in more recent years gained experience with chemically addicted physicians, I think it is evident that some physicians *are* different as a result of the manner in which they react to professional and social demands placed upon them.

We begin with a little higher than average God-given intelligence and have a higher degree of determination and ambition. These characteristics allow us to sit and compete in an examination for entrance into medical school. Progress through the years of medical school is then pretty much assured, assuming some degree of financial support has been forthcoming.

The medical degree confers an honor and obligation to care for the many ills of our fellow man. The knowledge bestowed upon us allows us the privilege of helping our patients through their physical and emotional needs, and offers us the opportunity to gather for ourselves material objects, not readily available to most Americans.

Nowhere in these endeavors toward success are we granted a degree in wisdom. Wisdom is the result of emotional and spiritual maturity which has its roots early in the molding years, beginning with the value system established in a loving, stable family structure. This basic acquiring of maturity proceeds throughout our lifetime as long as there is no outside adverse influence in our cognizant ability to assimilate our basic value system into resolution of life's challenges. Whatever adverse influence that enforces our own self-centeredness, to the exclusion of our own value system, will bring about solutions to challenges coming down the pike that will generally benefit no one.

Mood-altering chemicals, including alcohol, when consumed inappropriately, are a prime example of adverse influence. Chemical addiction is a self-centered progressive disease, over which the sufferer has no control and, unless treated, results in multiple

obvious and subtle consequences in addition to death by accident and disciplinary action by regulatory boards. Current estimates are that 10-20% of physicians will become impaired at some point in their professional careers. The magic line between "social consumption," abuse and addiction are rarely recognized by the physician or his peers. What early signs and symptoms are important to recognize, and when to intervene, becomes crucial to physicians involved in the disease process.

Medical school did not prepare us for life stresses unique to our profession over and above those of the usual family and social interpersonal relationships. We are asked to be: always on call; to be "omnipresent," all powerful; stop any disease or tumor; always non-judgmental, infallible; never make a mistake or risk getting sued; asexually examine all those naked people, talk about sex with them and never get aroused.

We are asked to be unaffected by blood, guts or death. We are asked to be a perfect father, lover, friend, but be willing to abandon these people immediately when the beeper goes off, and asked to be super-responsive to other doctors.<sup>1</sup>

The great majority of practicing physicians have healthy coping mechanisms to address these stresses as part of the job. However, some do not and look to some outside assistance, such as alcohol or other chemicals to cope. Over time, their chemical use may increase in response to their need for assistance in coping. A denial mechanism develops and when a consequence occurs associated with their chemical use, they do not recognize the relationship.

Physicians are different in their progressive chemical abuse. They have the ability to self-medicate, and the ability to do it alone. They are clever, and through an intense denial system lie about time, dose, and frequency. The nature of the practice requires a higher element of control, which extends to those around them, including their families. They are frequently more married to their jobs than to their spouses. As impairment progresses, work is the last thing to go,

---

\*Medical Director, MASA Impaired Physicians Program

divorce and other family disruption having gone before.

They have a problem letting other people know they have a problem and they rarely request evaluation and treatment voluntarily. They therefore may need recommendation for evaluation based on only a little bit of evidence.

The St. Paul Fire and Marine Insurance Co. *Human Factors Guide, Physicians Alcohol and Drug Impairment*, elicits "red flags" in behavior which should alert the need for evaluation by a person with special expertise in substance abuse: Arrest for driving while intoxicated, intoxication at social events outside the practice of medicine, alcohol on the breath while performing professional duties, personality change, repeated "illness" on Mondays, neglecting medical staff duties, missing appointments with patients, inappropriate or dangerous orders, and unusually high doses or wastage in drug logs.

One or more of these "red flags" may signal significantly advanced disease.<sup>2</sup> Any one of these "red flags" usually represents only the tip of the iceberg. Solo practitioners have an unusual opportunity to isolate. Social withdrawal, complaints of forgetfulness from nurses and patients, a malpractice suit, conducting rounds at unusual hours, and unexplained absences indicate cause for concern.

How serious do things need to be and how much information does one need to proceed with consultation for intervention? Generally a high index of suspicion is all that is needed. Colleagues tend to diminish significance of signs and symptoms, and to consider major problems, such as complaint with spouse or nurses, as isolated events not needing attention. Unfortunately our medical education did not prepare us to recognize the addiction process in our peers. The biggest mistake is to do nothing. "Primum non nocere" - first, do no harm - applies particularly in the scenario.

A conspiracy of silence may result from lack of basic knowledge of the disease process, fear of reprisal or social stigma, or a simple feeling of helplessness. The simple idea that one of "us" may have an alcohol problem may be too uncomfortable for further consideration. Too often our impaired colleagues

progress to advanced disease and indigency prior to intervention.

Life's learning process demands that we be open-minded to signs and symptoms and behavior that our addictive peers may present. Refusing to accept painful realities in ourselves in dealing with our peers, coupled with inventing excuses so as to make unacceptable behavior seem acceptable (denial and rationalization) delays needed consultation.

Blaming, trying to make other people responsible, is an immature behavior response in substance-abusing individuals which should be recognized. Minimizing, intellectualizing, and justifying are personal defensive mechanisms many physicians consciously or subconsciously utilize in dealing with unpleasant situations. We are all guilty at some point with these defense mechanisms to varying degrees. It is extremely important, however, that they be readily acknowledged in our impaired peers and in ourselves when we evaluate them.

We have an ethical and legal responsibility to seek evaluation for our colleagues who may have a disease process which could progress to professional impairment. "In addition to compensatory damages, physicians who knowingly allow an impaired colleague to continually practice, whether the problem is substance abuse, mental illness or physical decline, may be liable for punitive damage which most professional liability policies don't cover".<sup>3</sup>

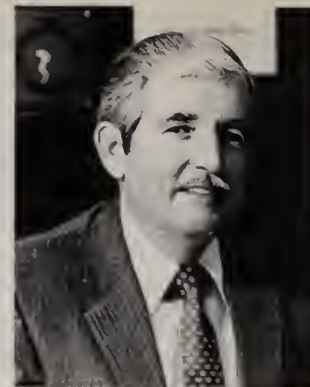
Alabama law requires reporting of physicians who may be impaired. The law also provides confidentiality and protection for physicians from liability for reporting, and allows the Alabama Impaired Physicians Committee under the Medical Association of the State of Alabama to advocate and evaluate the physician who may be ill.

The confidential call to the Alabama Impaired Physicians Program, 1-800-392-5668 or 205/261-2044, will begin the process of helping the compliant physician while protecting his license.

### References

1. Medical Director, Florida Impaired Physicians Program, Personal Comments
2. AMA News, November 11, 1991, Page 13
3. Larkin, Howard - In AMA News, November 13, 1991, Page 13





S. Lon Conner  
Executive Director, MASA

## Killing the Golden Goose

**D**isturbing things are happening to the fundamental economic structure of the United States that go far beyond the present double-dip recession, itself very different from previous downturns. These ominous trends will impact heavily, I believe, on medical practice.

Heretofore, blue collar workers have been the principal victims of periodic hard times. This time, they are being joined in the unemployment lines by many of the professional class of middle managers, computer programmers, well-paid engineers, even scientists in industrial research.

The business magazines are full of upper-level unemployment horror stories stemming from the rash of mergers and acquisitions but also from downsizing huge corporations where front-office employees had assumed that they had job security for life. The 74,000-job cutback announced by General Motors just before Christmas is not confined to those on the shop floor; it also includes many in the upper echelons.

Economists and industrialists agree that many of the jobs now being lost are gone forever. These workers, blue and white collar alike, will never be re-hired nor will replacements. The unique and disquieting fact of so many of the thousands of recent layoffs is that these are not the usual temporary furloughs but job *abolition* as business and industry restructure to meet changing times, including foreign competition.

Companies that had the reputation of lifetime paternalistic protection of their workers have become ruthless in their cutbacks, eliminating the jobs of men and women at the peak of their careers. Industrialists rationalize the expulsions by explaining that this country is

at war — a war of survival in world markets.

Until now, recessions have all looked pretty much alike — the country just sweated them out as the blue collar workers survived on unemployment insurance, company and union benefits until the inevitable upturn resulted in their rehiring. Tough on some but limited in impact and duration.

All that has changed; hence the national debate over what to do. The old Keynesian pump-priming could help in the short term — reduced taxes, federal works to spur the economy, lowered interest rates to encourage investment, etc. But these measures will do little, most economists are saying, to ameliorate the employment stress resulting from fundamental restructuring of the way America has produced for generations.

Behind it all is massive and unprecedented debt — public, industrial and individual — the product of years of reckless spending as the country, at all levels, proceeded to mortgage its future, spending far beyond income as if there were no tomorrow. What we are in now is tomorrowland, where the chickens roost.

With a national debt soaring toward \$4 trillion, corporations are staggering under unprecedented loan burdens, and millions of individuals are in hock up to their chins. Even such a mammoth empire as General Motors, which just recently had a cash reserve that was the envy of many whole countries, is virtually broke, according to *Fortune*.

It may be comforting to blame it all on the Japs and the Germans, but most of our plight is our own doing: we ate the seed corn. When we demand that the government spend money and cut taxes to relieve our present pain, all we are doing is begging for the hair



# SYSTEMS CORPORATION

Medical Systems Consultants

Suite 2108, First National Bank Building

Mobile, Alabama 36602

1-800-239-1717

(In Mobile, call 432-1313)

## Universal Electronic Billing !

- (1) Now your practice can electronically bill all third party payors — in care of one location.
- (2) Now you can put more money in your pocket, much faster!

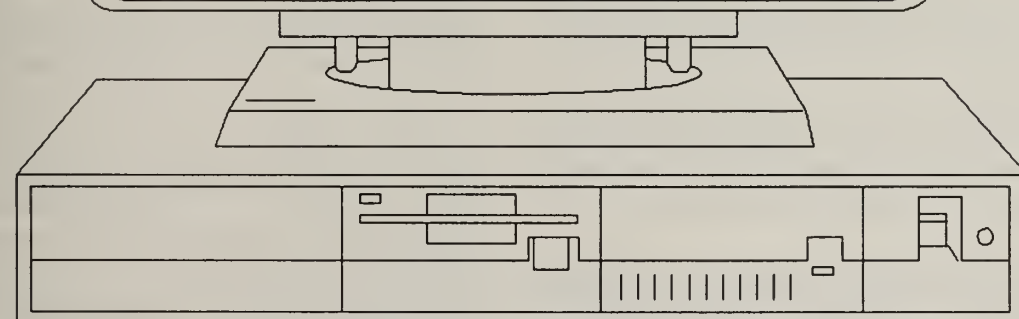
### Your Cost Today?

\$695 for the software — installed in your office — on your machines!

45¢ per Electronic Charge transmitted!

For Further Information, Please Call:

**1-800-239-1717**



**SYSTEMS CORPORATION**

### Comparisons

- I. In 1990, the administrative cost of processing a paper claim approximated \$3.50. Utilization of our Electronic Billing System can today reduce costs to \$1.50 per claim, approximately.
- II. Reimbursement from paper claims can take 7-8 weeks versus 2-3 weeks from Electronic Claims.



of the dog. "Don't let them take it away" is a plaintive cry being heard once again across the land. Just one more drink of that heady concoction.

No matter that the national debt is now far beyond the cumulative total of all debt since the republic was born, Democrats and Republicans alike can be heard demanding *more debt* as the solution — cut taxes and put everything on the cuff. We've been doing that so long now we know no other way; profligacy has become a way of life. The nation is addicted to excess and stealing from future generations.

In the past, when we did face up to economic reality, the air was filled with soak-the-rich demands and much breast-beating for the poor, but in the end those who paid the bills were always the same group — the middle class. Tax the rich at 90% and it would only be a drop in the bucket. There aren't enough of them. The money, like the nation's principal strength, has always been in the middle class, the ultimate cost-shiftee. But the middle class is not only suffering from economic stagnation; it is also shrinking.

For more than three decades after World War II, most Americans believed they lived in the middle class, which remained pretty stable through the years at 75% of the population. For years, economists puzzled over the uncanny stability of the middle class. That is until the 1980s introduced a startling new trend — shrinkage. This from "The analytical Economist" in *Scientific American*:

"Expansions and recessions barely dented it. The Great Society and a raft of other social programs couldn't dislodge it.

"Some people moved up from poverty, others fell down; some became wealthy, others dropped back to the middle class. Tax cuts and tax hikes alike made little difference on the proportions of the rich, middle and poor.

"Until the 1980s, that is. The past decade has brought such sharp changes in the distribution of income in the U.S. that ... economists are even more at a loss to explain income disparities than they were in the face of earlier stability. The middle class, which for decades comprised roughly 75% of the adult population, shrank by about 10%."

By some estimates, the shrinkage may have been as great as 20%, from 75% to 60%. Until around 1980, migrations to and from the middle class more or less offset each other, leaving the relative size of each income bloc largely intact, according to trackings by the University of Michigan and Syracuse. *Scientific American*:

"For instance, during those years a middle class

adult — one who earned between \$18,500 and \$55,000 in 1987 dollars — faced about a 6% chance of entering the upper class within three years and a similar likelihood of slipping into the lower class.

"At the same time, 31% of upper-class adults would fall from economic grace even as 35% of lower-class adults would climb up into relative comfort."

This had held fairly constant for decades. But it all began to change radically about 12 years ago. Since then, about 2% more people have risen to the upper income bracket, and 30% more have fallen into the lower economic tier.

At the same time, fewer people from either the upper or lower income groups have been moving into the middle group, further shrinking its relative size. *Scientific American*:

"The most proximate cause of middle class erosion is the changing structure of the job market. High-status workers are earning more, while lower-ranking workers are earning relatively less. Disparities between top earners and bottom earners have been increasing since the 1960s, but after the late 1970s the gulf between the working poor and the working rich widened even faster. Peter Gottschalk of Boston College calls the result a 'tidal wave of inequality in earned income'."

Fewer than 3% of European households earn less than 50% of the median income for several years in a row, compared with 14% of U.S. households. If you think that is because of the racial and ethnic diversity of the U.S. compared to Europe, *Scientific American* answers:

"Even if blacks, the racial group with the highest poverty level, are eliminated from the calculations, the U.S. still has twice the European rate of poverty .... And American poor work just as much as the poor of the European nations, if not more. More single mothers in the U.S., for example, have jobs than in Great Britain..."

Of course, it is the middle class, principally, that must provide the revenue to support the poor, further burdening the class often called the backbone of the nation. Also, many of those moving from the middle class to the upper class made the jump because of income from two careers, which distorts the migration:

"In addition, many are moving up simply because the salary of the top 10% of wage earners is now at least 3.8 times that of the bottom 20%, as compared with 2.6 only 25 years ago."

*Scientific American* concludes that while no one is presently predicting that the middle class will become

a minority, at least before the turn of the century:

"Nevertheless the trend seems ominous. As long as the work force is increasingly segregated into professionalized high-paying jobs and less skilled, low-paying jobs... the middle class will be threatened."

And if the ranks of those in the high-paying jobs are being decimated, as in the current wave of cut-backs and downsizing, who will be able to pay for all those present proposals for some kind of universal health care? The sponsors either say that their plans won't really cost anything or that the costs will be borne by business. But business passes its costs on to — yep, largely the middle class.

The Washington cost shifters seem determined to ride this horse to death. A reporter covering the New Hampshire primary campaign wrote that ALL of the candidates shared a common argument — that the economy can be rejuvenated, the deficit erased and a massive federal health care plan put in place *at absolutely no cost whatever to taxpayers*.

We can have all this and just about anything the

voters want, *and a tax cut at the same time*.

Sound familiar? They learned that, economists point out, from Ronald Reagan and George Bush. As one said, there is never a downside to promising voters pie in the sky. Not, that is, unless you slip up and mention that the piper must some day be paid by somebody. The last presidential candidate to try that was Walter Mondale, and he vanished without a trace.

But the incredible shrinking middle class knows, and politicians know it knows, that sooner or later it will be presented the bill for whatever promises are actually kept.

As long as such egregious economic lies are the fashion, the American economy will continue downhill. And when we can no longer escape the day of reckoning, the middle class will be clobbered again and its numbers will decrease still more.

It's all so maddeningly idiotic. If Diogenes were to return and find himself haplessly wandering through this year's presidential primaries and general election, he might well extinguish his lantern for good.

# 33.8%\*

\*PERSONAL PORTFOLIO MANAGEMENT FOR INDIVIDUALS, CORPORATIONS, AND RETIREMENT PLANS BY ONE OF THE TOP RANKED PORTFOLIO MANAGERS IN THE COUNTRY

\*PORTFOLIO HOLDINGS INCLUDE HOME DEPOT, CRACKER BARREL, U.S. SURGICAL, AMGEN, WAL-MART, PEPSICO

\*PHYSICIAN REFERENCES AVAILABLE

\*REGISTERED WITH THE SECURITIES AND EXCHANGE COMMISSION AS AN INVESTMENT ADVISORY FIRM

## CAMBRIDGE EQUITY ADVISORS

5214 MARYLAND WAY, SUITE 309, BRENTWOOD, TENNESSEE 37027

(800) 426-1391 (615) 371-9002

\*AVERAGE ANNUAL GAIN OVER THE PAST 5 1/2 YEARS

RATE OF RETURN IS CALCULATED ON TIME-WEIGHTED BASIS AND IS NET OF ALL FEES AND COMMISSIONS. RESULTS INCLUDE REINVESTMENT OF INCOME RETURNS PRIOR TO JANUARY 1, 1990 FROM AUDITED MODEL PORTFOLIO. AFTER THIS DATE ARE OF ACTUAL ACCOUNTS MANAGED OVER \$100,000. PAST PERFORMANCE IS NO GUARANTEE OF FUTURE CONTINUED PERFORMANCE.





William D. Lazenby, M.D.  
President, MASA

## ... And Then Some

*And whosoever shall compel thee to go a mile, go with him twain.*

— Matthew 5:41

This familiar quotation is one of a family of biblical injunctions to find the peaceful way through compromise and accommodation. Together, these metaphors offer an alternative to the inevitable conflict of a contrary doctrine, an eye for an eye and a tooth for a tooth (a doctrine of revenge that haunts the lands of the Bible even today).

Western civilization and its institutions are built on this bedrock premise: that only through reasoned compromise between conflicting views can an orderly society exist. All the deliberative bodies of the West — whether parliament, legislature or congress — are crafted out of this fundamental concept.

The only alternative to peaceful resolution of differences is constant revolution, as those of one persuasion seize control, only to be replaced in time by those of the opposite. We have seen this in the Latin American countries for generations, and in the Middle East for centuries.

It is in fact this basic western idea of the resolution of division and conflict that we are trying to impose on Arab and Jew alike in the Middle Eastern talks. Once again the United States is saying to that region of constant strife that only through negotiation and compromise, with each side giving a bit, can there ever be lasting peace. If the world has learned nothing else from the teachings of the ancients, it should certainly have learned this.

The same principle undergirds the AMA's new posture in Washington. I am sure you have noticed that, under Dr. Todd, the AMA does not say "never" but "let's talk." Dr. Todd is a forceful, strong leader, quick and vigorous in his defense of doctors from irresponsible criticism. But his refreshing new approach is to say that everything is negotiable, everything is on the table, except the central credo of the doctor-patient relationship and the paramount role of the physician in determining the course of care.

We are stonewalling nothing but that: this is his constant refrain, and he has gained new respect for medicine in the halls of Congress — as witness the overwhelming support of both parties in both houses when HCFA tried to pull a fast one by manipulating the Medicare conversion factor. Dr. Todd led the thunder of organized medicine and we got back most of what we had been illegally denied.

The moral principle here was far more important than dollars; we had accepted, on trust, our government's assurance that there would be no hanky panky. When there was, the issue became one of breach of faith between a proud profession and its government. HCFA had no friends in court.

We will go the second mile, in Washington or Montgomery, in all matters save only those bearing on our sacred duty to the patient and as the sole advocate of that patient. Only this central doctrine is off-limits for negotiation or compromise.

On the workers compensation issue, for example, we have tried to see the issues from the viewpoint of our friends in business and industry. We know they

# Whose Retirement Plans? Not Yours - That's For Sure !

Think About All The Retirement Plan Costs You Pay. Lawyers - Trust Departments -



Stock Brokers - Accountants - Investment Advisors - Plan Administrators - ETC., ETC., ETC.

**Only Incredible Investment Returns Would Save Your Retirement Money From Being In a Perpetual Bear Market !**

Would You Like To Convert To Retirement Plans



**Which Grow Assets For You?**

THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

MAR 30 1992

We offer complete investment management on an individualized basis for every physician as well as complete retirement plan services which include every service listed above.

Our comprehensive system will net most physicians more profit on their retirement monies than other alternatives.

Our charge is an inexpensive % of your assets under our management.

## INVESTMENT ADVISORY & MANAGEMENT CORPORATION

Suite 2110 First  
National Bank Building  
Mobile, Alabama 36602

1-800-239-1666  
In Mobile (432-1666)



And, if we don't obtain good results for you, our compensation suffers.

References? Yes. We have the support of our existing physician clients — and they are very willing to discuss our services for them with you.

For references or further information, such as a copy of our free retirement plan services pamphlet, please contact us.

Registered Investment Advisor

With the U.S. Securities Exchange Commission and The States of Alabama and Mississippi

This document is proprietary and confidential information of Investment Advisory & Management Corporation, Copyright applied for.



have a problem and we tentatively agreed to a fair compromise. All along, however, we have adamantly insisted that doctors will never cede their authority over patient care to a medical czar with statutory power to determine who gets what care, where and by whom.

We can negotiate on the business aspects of medicine; we can never negotiate away our professional duty and responsibility, which is precisely what the Director of the Department of Industrial Relations demanded in his bill.

This year in Washington there will be many attempts to legislate "health care reform." Some of these would seem to insure health care chaos. All of them, in one way or another, promise more than they can deliver, for the simple reason that they either avoid the funding question, demagogue it by assuring us that it's all free, or provide that the bill will be paid by "somebody else."

Yet, not all of the measures are all bad. There may be some merit in even the worst of them and I would expect AMA will concede as much while attempting to preserve the essential infrastructure of the finest health care system in the world. We will negotiate a point there, counter-propose one here, and attempt to shape a reasonable, evolutionary concept as near as possible to the Health Access America model AMA has put on the table.

Certainly, it will not go 100% our way; those days ended in the mid-60s when Medicare-Medicaid was passed, heedless of AMA's warning that, as constituted, it was headed for bankruptcy.

Political pundits tell us that whatever emerges in this presidential election year will be a foundation for future incremental expansion, not a final product. All the more reason that medicine must insist on a sound foundation; above all, medicine must be intractable in rebuffing all challenges to the decision-making authority of the American physician. We are prepared to negotiate on all matters but that, I believe.

Now I know that there is a significant element of physicians who feel we should always oppose any change at all. But total, massive resistance would spell massive defeat. If ever there was a time when the biblical second mile is indicated, 1992 is it. Our arguments must be reasonable, our posture flexible.

Inflammatory rhetoric on our part may please some physicians, tired of their role as whipping boy for reckless politicians, but it would be woefully counter-productive. If our reaction to every proposal or concept is automatically negative, we will have no credibility at all to push for those elements patients and

physicians absolutely must have if American health care, as we know it, is to survive.

There is no better way to win over adversaries than by exhibiting a willingness to give-and-take in the American tradition. To protect what is essential in medicine, we must be prepared to yield on peripheral matters, to go the second mile.

Emotionally, I suppose, all physicians are biased in the direction of absolutely no compromise. But we also know that it is far better to bend than to break.

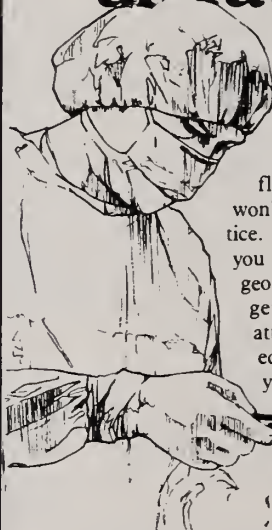
The second mile, after all, is not an entirely new concept. It has been tested by centuries in Western democracies.

---

*All government—indeed, every human benefit and enjoyment, every virtue and every prudent act—is founded on compromise and barter.*

—Edmund Burke, 1775

## An Officer and a Surgeon



If you're a surgeon looking for a change of pace and a chance to sharpen your surgical skills, try your hand in the Air Force Reserve. Serve part-time. Our flexible participation schedule won't interfere with your private practice. Depending on your experience, you may qualify for the Flight Surgeon Program. As an officer, you'll get good pay, benefits and paid attendance to continuing medical education (CME) activities. Serve your country. Serve yourself. For more information, call (404)421-4892. Today's Air Force Reserve...it's a great way to serve.

**AIR FORCE RESERVE**

14-214-0004

**A GREAT WAY TO SERVE**



## Pain relief for providers that's easy to swallow.

If your practice is like most, filing insurance claim forms and waiting for eligibility information is a major headache. The problem is, it's a slow, manual process which can restrict your cash flow. And that's painful for any business.

BellSouth Corporation and Blue Cross and Blue Shield of Alabama have a simple prescription for this really BIG headache: The BellSouth *Electronic* PPO.

If you are a provider servicing BellSouth employees and filing claims to Blue Cross and Blue Shield of Alabama, you may qualify to join the *Electronic* PPO program and:

- **STOP LOSING REVENUE** for services rendered on **NON-eligible** patients
- **Transmit ALL** claims accurately and electronically
- **Receive** claims payments faster
- **Verify** insurance coverage electronically
- **Identify** pertinent waivers and restrictions

So, if your practice suffers from sluggish cash flow and the pain of overwhelming insurance paperwork, **call 1 800 225-5056** for relief.



# **BELLSOUTH**



# Hospitalized Tornado Victims

*LeRoy F. Harris, M.D.\**

## ABSTRACT

We reviewed the clinical findings of 59 patients admitted to Huntsville's three hospitals during the first 24 hours after the November 15, 1989, tornado and as a result of injury caused by the tornado. Fracture of a bone was the most common injury followed by soft tissue trauma and infection. A variety of non-traumatic conditions also were encountered. Fractures were more frequent above the waist than below and five fractures became infected resulting in osteomyelitis. Infections most often involved the urinary tract and bone and were caused primarily by aerobic gramnegative bacilli. The hospital mortality rate was 7%.

On November 15, 1989, a violent tornado devastated Huntsville, Alabama. Initially 17 people were killed and nearly 300 were treated at the emergency rooms of Huntsville's three local hospitals. Eventually 59 patients were admitted to the hospitals during the first 24 hours after the tornado and as a result of injury caused by the tornado. We review the clinical findings of these patients and compare them to those of other tornado victims.

## PATIENTS AND METHODS

We reviewed the charts of all patients admitted to Huntsville's three local hospitals during the first 24 hours after the tornado and as a result of injury caused by the tornado. Medical and surgical conditions were defined by physician diagnosis. Organisms were identified by routine microbiologic techniques.

---

\*Clinical Associate Professor of Medicine, School of Primary Medical Care, University of Alabama School of Medicine at Huntsville, Suite A, 101 Bob Wallace, Huntsville, Alabama 35801.

Table I - Injuries of tornado victims

Injury	Number of injuries
Fracture	44
Soft tissue trauma	25
Infection	20
Cerebral concussion	4
Visceral contusion/laceration	3
Hemopneumothorax	2
Acute respiratory distress syndrome	2
Atrial fibrillation	1
Myocardial infarction	1
Perforated duodenal ulcer	1
Subdural hematoma	1
Acute leukemia	1
Acute renal failure	1

## RESULTS

Of the 59 patients, 31 were male and 28 were female. Their age ranged from 4 to 89 years and averaged 37 years. Four of the patients died resulting in a 7% mortality rate. Table I describes the injuries of the patients. Fracture of a bone was the most common injury followed by soft tissue trauma and infection. Less common conditions were cerebral concussion, visceral contusion/laceration, hemopneumothorax, and acute respiratory distress syndrome.

Table II lists the fractures of the 59 patients. The ribs were most frequently involved followed by the spine, clavicle, humerus, and skull.

Less frequently fractured were the pelvis, femur, ankle, radius, and facial bones.

Table III enumerates the infections encountered in the 59 patients. Urinary tract infections and infected fractures resulting in osteomyelitis were most frequently encountered followed by pneumonia, soft tissue infection, and infected IV site. Gram negative organisms were isolated much more commonly than gram positive organisms.

# FREEDOM FROM PAIN!

**Extra strength pain relief  
free of extra prescribing  
restrictions.**

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

## Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

## The heritage of VICODIN<sup>®</sup>,\* over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin ES** (III)

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

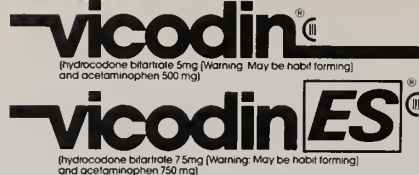
**Tablet for tablet, the most potent analgesic you can phone in.**

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit





**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

**WARNINGS:**

**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**PRECAUTIONS:**

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

**Usage in Pregnancy:**

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:**

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

**DRUG ABUSE AND DEPENDENCE:**

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

**OVERDOSAGE:**

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

**Table II - Fractures of tornado victims**

Location	Number of fractures
Ribs	6
Spine	5
Clavicle	5
Humerus	4
Skull	4
Pelvis	3
Femur	3
Ankle	3
Radius	3
Facial bones	3
Hand	2
Wrist	1
Hip	1
Sternum	1

## DISCUSSION

Tornadoes, hurricanes and floods are the three types of natural disasters which cause the greatest devastation in the United States with tornadoes being the most violent and lethal. Tornadoes occur during warm, humid weather, usually in association with severe thunderstorms, and are composed of winds rotating at high velocity.<sup>1</sup>

Approximately 20% of the patients treated in Huntsville's emergency rooms for injuries sustained during the tornado were admitted to the hospitals. This is remarkably similar to the 19% hospitalization rate observed during the Marion, Illinois, tornado of 1982. Interestingly, only 39% of people examined in the emergency rooms in Marion were injured as a direct result of impact. The remainder were harmed during rescue and clean-up operations and while walking in the disaster area.<sup>2</sup> This same phenomenon has been observed during the last four major military conflicts involving U.S. military personnel (World Wars I and II, Korea and Vietnam) and almost certainly will be confirmed during the recent Persian Gulf War; namely, that hospitalization for diseases and non-battle injuries far exceeds admission for combat-related wounds and injuries.<sup>3</sup>

Fracture of a bone was the most common injury observed in our hospitalized patients, followed by soft tissue trauma, infection, cerebral concussion, visceral trauma, hemopneumothorax and adult respiratory distress syndrome. The data from two other tornadoes relates to patients seen in the emergency room

Revised June 1989

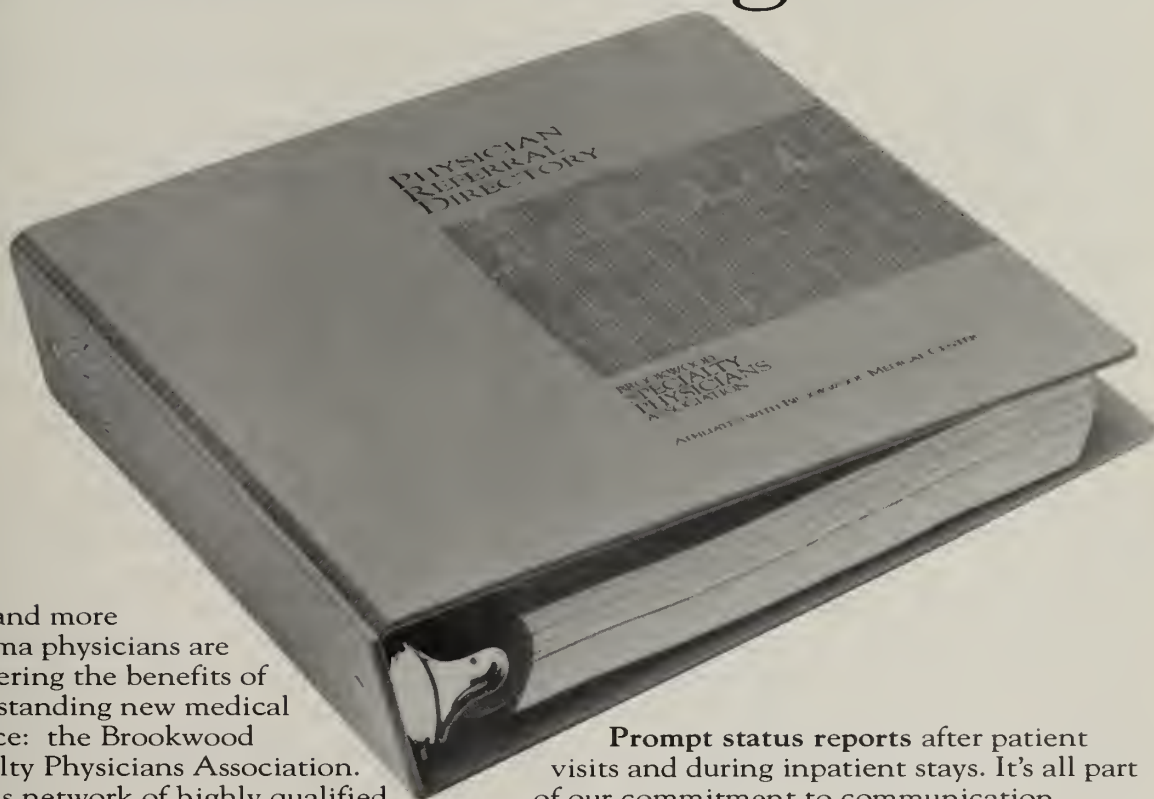
Knoll Pharmaceuticals  
A Unit of BASF K&F Corporation  
Whippany, New Jersey 07981



5864

BASF Group

# Presenting The Medical Resource That More Alabama Doctors Are Referring To.



More and more Alabama physicians are discovering the benefits of an outstanding new medical resource: the Brookwood Specialty Physicians Association.

This network of highly qualified physicians represents virtually every medical specialty. But it's more than a group of doctors. It's a total system of convenient, comprehensive referral services:

**Physician Referral Directory**, a free, user-friendly guide to all our specialists.

**Toll-free referral line** for setting up referrals and making appointments.

**Prompt status reports** after patient visits and during inpatient stays. It's all part of our commitment to communication—ensuring that you, the referring physician, are an integral, informed part of the “care loop.”

For more information, or for your free Physician Referral Directory, call 1-800-292-4859 (877-1887 in Birmingham).

And see for yourself why more Alabama doctors are referring to the physician network that wrote the book on referral services.

BROOKWOOD  
SPECIALTY  
PHYSICIANS  
ASSOCIATION

AFFILIATED WITH BROOKWOOD MEDICAL CENTER

THE PHYSICIAN NETWORK THAT SPECIALIZES  
IN CONVENIENT, COMPREHENSIVE REFERRAL SERVICES.



Table III - Infections of tornado victims

Type of infection	Number of infections	Organisms causing infection
Urinary infection	5	<i>Escherichia coli</i> , <i>Pseudomonas aeruginosa</i>
Osteomyelitis	5	<i>Ps. aeruginosa</i> , <i>Staphylococcus aureus</i> , <i>Enterobacter cloacae</i>
Soft tissue infection	3	<i>Ps. aeruginosa</i> , <i>Serratia marcescens</i> , <i>Aeromonas hydrophilia</i> , <i>Klebsiella oxytoca</i> , <i>E. aerogenes</i>
Pneumonia	3	<i>Ps. aeruginosa</i> , <i>S. marcescens</i> <i>E. aerogenes</i>
IV site infection	2	<i>S. aureus</i> , <i>E. aerogenes</i>
Prepatella bursitis	1	<i>S. aureus</i>
Otitis externa	1	<i>Ps. aeruginosa</i>
Disseminated candidiasis	1	<i>Candida albicans</i>

(and not just admitted to the hospital). During those disasters lacerations and soft tissue injury outnumbered fractures.<sup>24</sup> In our patients bone fractures were more frequent above the waist than below. The occurrence of medical emergencies including atrial fibrillation, myocardial infarction, perforated duodenal ulcer, acute leukemia and acute renal failure in our patients demonstrates that nontraumatic disease can result from a tornado as well as traumatic injury.

Infection was relatively frequent in our patients and usually involved the urinary tract, bone, soft tissue, and lung. Previous studies of wound infections in tornado casualties have emphasized that they are common and caused by soil contamination rather than a nosocomial source. Aerobic gram-negative bacilli predominate as etiologic agents and there is a notable absence of clostridial infections, including gas gangrene, similar to our experience. Suggested management of wounds consists of thorough debridement of environmental debris and devitalized tissue, antitetanus prophylaxis and delayed primary wound closure.<sup>56</sup> The use of prophylactic antibiotics is problematic, being advocated in one series<sup>5</sup> but not in another.<sup>6</sup>

Many of the infections experienced by our patients were of nosocomial origin, a fact attributed, at least in part, to the large number of patients cared for over a

short period of time. Aerobic gram-negative bacilli and *S. aureus* were isolated from the infections, as expected by their nosocomial acquisition.<sup>7</sup> The presence of such serious hospital-acquired infections as Foley catheter associated urinary tract infection with septic shock, pneumonia in mechanically ventilated patients, infected IV catheter sites requiring vein excision, and disseminated candidiasis emphasizes the need of meticulous infection control practices during emergency situations.

## BIBLIOGRAPHY

1. Anonymous. Mortality from tornadoes, hurricanes and floods. Statistical Bulletin, Metropolitan Life Insurance Co. 1974 Dec:4-7.
2. Duclos PJ, Ing RT. Injuries and risk factors for injuries from the 29 May 1982 Tornado, Marion, Illinois. *Int J Epidemiol* 1989; 18:213-219.
3. Palinkas LA, Coben P. Disease and non-battle injuries among marines in Vietnam. *Milit Med* 1988; 153:150-155.
4. Morris BAP, Armstrong TM. Medical response to a natural disaster: the Barrie tornado. *Can Med Assoc J* 1986; 134:767-769.
5. Ivy JH. Infections encountered in tornado and automobile accident victims. *J. Indiana State Med Assoc* 1968; 61:1657-1661.
6. Gilbert DN, Sanford JP, Kutscher E, Sanders CV Jr, Luby JP, Barnett JA. Microbiologic study of wound infections in tornado casualties. *Arch Environ Health* 1973; 26:125-130.
7. File TM Jr, Tan JS. Treatment of bacterial skin and soft tissue infections. *Surg Gynec Obstet* 1991; 192 (Suppl 91):17-24.

## ACKNOWLEDGEMENTS

The author thanks the following physicians for providing clinical information about the hospitalized tornado victims: Kendall Black, M.D., Richard C. Burnside, M.D., Thomas M. Griggs, M.D., Jeremy K. Hon, M.D., Richard Martin, M.D., Howard G. Miller, M.D., Charles R. Morley, Jr., M.D., F. Calame Sammons, M.D., S. Rao Yerubandi, M.D., Peter S. K. Yu, M.D.

The author also thanks Juanita Spicer for preparation of the manuscript.

# EIGHT GOOD REASONS TO SWITCH HEALTH INSURANCE COMPANIES

---

## 1 LOW RATES

*Compare our premiums to what you're paying now*

## 2 CHOICE OF DEDUCTIBLES WITHIN YOUR GROUP

*Mixing deductibles within your group can help control expenses*

## 3 PERSONAL SERVICE

*We're large enough to meet your needs - yet small enough to care*

## 4 A TRADITION OF TRUST

*We've been serving health care professionals exclusively since 1978*

## 5 AN A+ FOR FINANCIAL STRENGTH AND STABILITY

*Affiliated with Mutual Assurance, rated A+ by A.M. Best*

## 6 A CHOICE OF PROVIDERS

*Total freedom to choose the doctors you want to use*

## 7 RAPID CLAIMS HANDLING

*Most claims paid within two weeks*

## 8 NO PRE-CERTIFICATION REQUIRED

*No administrative headaches or hassles for you or your family*

IF YOU THINK THESE ARE GOOD REASONS  
CALL 1-800 344-9588

**LifeSouth**

PROFESSIONAL'S HEALTH PLAN





NEW INDICATION

## ONLY ONE H<sub>2</sub>-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H<sub>2</sub>-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150 mg b.i.d.**, relieves heartburn in **86%** of patients after one day and **93%** after one week.<sup>1</sup>

**AXID**<sup>®</sup>  
nizatidine  

---

150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

# AXID<sup>®</sup>

## nizatidine capsules

**Brief Summary:** Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported, it was not possible to determine whether these were caused by nizatidine.

**Hepatic—Hepatocellular injury** (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated, however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP

[101591]

Additional information available to the profession on request.

**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY

## Questionable Conclusion

Editor, *Alabama Medicine*

I am writing about the article in *Alabama Medicine* entitled "Contemporary Results of Carotid Endarterectomy" by James B. Richardson, M.D. I would like to take issue with this article.

Dr. Richardson is a very skilled surgeon and the results of his surgical cases which he presented in this article are quite impressive. It is true that recent studies have clearly shown that carotid endarterectomy for SYMPTOMATIC CAROTID STENOSIS clearly decreases the risk of stroke in later life. I believe this is a clear indication for carotid endarterectomy as Dr. Richardson does.

Where I would differ is his conclusion that "carotid endarterectomy should continue to be employed in patients with significant carotid disease, regardless of symptoms, as long as the results of carotid endarterectomy in that surgeon's practice are excellent." There has never been a study — that is, a randomized double blind study — that has shown that surgery should be done in asymptomatic carotid stenosis. There are active studies in progress at this time, but I would hesitate as a journal to make this recommendation without clear studies to support this.

This is still a controversial field in neurology and vascular surgery. I would also differ with the opinion that carotid ultrasound is "quite satisfactory as a sole evaluation prior to surgery." Carotid ultrasound and its interpretation is quite variable from center to center. I have frequently seen poor correlation between carotid ultrasound and arteriography when performed when the carotid ultrasound is performed in outlying centers that perform very few of these procedures.

I would be very careful in recommending surgery to patients based on carotid ultrasound alone or asymptomatic carotid stenosis. I do not think that the literature clearly supports this at this time.

P. Caudill Miller, M.D.  
Montgomery





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association

# Newly Licensed Doctors

Cone, John Alan, M.D.  
1902 West Oak  
Jonesboro, AR 72401 or:  
Eye Center South  
2800 Ross Clark Circle, SW  
Dothan, AL 36301

McDaniel, James Donald, M.D.  
2205 Beltline Road, SW  
Decatur, AL 35609

Foxhall, Edward Neal, II, M.D.  
1315 Mulberry Street  
Montgomery, AL 36106

Rodriguez, Armando Victorino, M.D.  
2491 Meadow Ridge Lane, #B  
Montgomery, AL 36117

Rivas, Luis Arturo, M.D.  
AU Regional Hospital  
SGHR / Radiology  
Maxwell AFB, AL 36112

Tesoro, Augusto T., M.D.  
P. O. Box 478  
Carrollton, AL 35447

Walker, Allen Roy, Jr, M.D.  
7833 Second Avenue South  
Department Family Practice  
Birmingham, AL 35206

Abouljoud, Marwan Sayed, M.D.  
29174 Franklin Hills Drive, #205  
Southfield, MI 48034

Aguayo, Michele Anne, M.D.  
AU Regional Hospital - SGHF  
Maxwell AFB, AL 36112

Armstrong, Lorraine June, M.D.  
821 Tyler Circle, Apt. C  
Birmingham AL 35226

Coleman, Charles Stephen, M.D.  
801 Gaines Avenue, Suite 402  
Gadsden, AL 35903

Dang, Hai Van, M.D.  
USAMC / Dept. Ob-Gyn  
2451 Fillingim Street  
Mobile, AL 36617

Descartes, Maria, M.D.  
3561 Erica Way  
Birmingham, AL 35243

Dohrenwend, Michael Patrick, M.D.  
UAB/Department Gastroenterology  
UAB Station  
Birmingham, AL 35294

Edwards, Karen Annette, M.D.  
AU Regional Hospital  
Department Internal Medicine  
Maxwell AFB, AL 36112

Esquivel, Julio Antonio, M.D.  
14100 Cypress Court  
Miami Lakes, FL 33014

Fernandez, Joseph Anthony, M.D.  
Lyster Army Hospital  
Department Urology  
Ft. Rucker, AL 36362

Floyd, James Gerald, M.D.  
Jefferson Clinic, PC  
P. O. Box 55845  
Birmingham, AL 35255

Freedy, Robert Marvin, M.D.  
U A B / Department Radiology  
619 South 19th Street  
Birmingham, AL 35233

Graves, James Frederick, M.D.  
USAMC/Department Psychiatry  
2451 Fillingim Street  
Mobile, AL 36617

Harris, Paul Joseph, M.D.  
P. O. Box 280  
Department Anesthesiology  
Ocean Springs, AL 39564

Heldmann, Maureen Gail, M.D.  
UAB/Department Radiology  
6th Floor JT  
619 South 19th Street  
Birmingham, AL 35233

Howell, Willie Ree Allen, M.D.  
4257 Cave Spring Road  
Rome, GA 30161

Iyer, Sriram Sadasivan, M.D.  
UAB/Room 310 LHRB  
1919 Seventh Avenue South  
Birmingham, AL 35294

Jones, Monica Renner, M.D.  
#1 Calle Dos  
Department Ob-Gyn  
Key West, FL 33040

Kasmia, Abdel Hakim, M.D.  
USAMC / Department Neurology  
2451 Fillingim Street  
Mobile, AL 36617

Kezar, Laura Brooks, M.D.  
3505 Redmont Road  
Birmingham, AL 35213

Mallow, Gary William, M.D.  
2440 Chestnut Ridge Place  
Birmingham, AL 35216

Meythaler, Jay Merlin, M.D.  
UAB/Spain Rehabilitation Center  
UAB Station  
Birmingham, AL 35233

Moskovich, Arlene Suzanne, M.D.  
Yellow Bluff Clinic  
Route 1, Box 199  
Pine Hill, AL 36769

Nowack, William Jacob, M.D.  
USAMC/Department Neurology  
MCSB 1102  
2451 Fillingim Street  
Mobile, AL 36617

Nurre, Christopher Allen, M.D.  
1400 Perimeter Park West  
Department Family Practice  
Morrisville, NC 27560

Owen, James Elvin, M.D.  
1215 Terrence Place  
Dept. Emergency Medicine  
Charlotte, NC 28209

Pfister, Richard Charles, M.D.  
P.O. Box 1183  
Department Radiology  
Fairhope, AL 36532

Phillips, Barry Brent, M.D.  
Alabama Sports Medicine  
1222 14th Avenue South, Suite 109  
Birmingham, AL 35255

Reed, Ken, M. D.  
U TX Medical School-Neuropsychiatry  
P. O. Box 20708  
Houston, TX 77225

Ross, Brendan Sean, M.D.  
USAMC/Mastin Building, 4th Floor  
2451 Fillingim Street  
Mobile, AL 36617



# YOCON<sup>®</sup>

## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

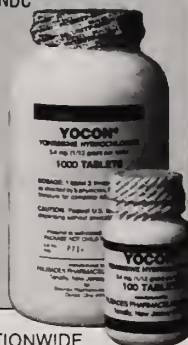
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES  
PHARMACEUTICALS, INC.**

219 County Road  
Tenafly, New Jersey 07670  
(201) 569-8502  
1-800-237-9083

Saddekni, Souheil, M.D.  
UAB/Department Radiology  
619 South 19th Street  
Birmingham, AL 35233

Schulze, Richard Randolph, Jr., M.D.  
USAMC/Dept. Ophthalmology  
P.O. Box 8448  
Mobile, AL 36689

Shah, Malavika Kirit Kumar, M.D.  
215 Perry Hill Road  
Dept. Internal Medicine  
Montgomery, AL 36109

Sittig, Armanda Margaret, M.D.  
9719 Powhatan, Apt A-4  
San Antonio, TX 78230 or:  
833 Tullahoma Drive  
Auburn, AL 36830

Speed, James Byron, M.D.  
UAB/Department Radiology  
619 South 19th Street  
Birmingham, AL 35233

St. Clair, Jane Turley, M.D.  
Shoals Medical/Dept. Anesthesiology  
309 West State Street  
Muscle Shoals, AL 35661

Steinbook, Michael Neil, M.D.  
2300 Manchester Expressway, Building G-203  
Dept. Gastroenterology  
Columbus, GA 31904

Suresh, Keshava G.N., M.D.  
USAMC/Department Anesthesiology  
2451 Fillingim Street  
Mobile, AL 36617

Val-Gallas, John M., M.D.  
Providence Park Ob-Gyn  
6701 Airport Blvd., Suite B-127  
Mobile, AL 36608

von Oldenburg, Albert A., M.D.  
Greil Memorial Hospital  
2140 Upper Wetumpka Road  
Montgomery, AL 36107

Vuk, Stanko, M.D.  
500 Jackson Street, Apt. 206  
Daphne, AL 36526

# THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

## \$10,000 - \$20,000 - \$30,000

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY**  
**ORTHOPAEDIC SURGERY**  
and  
**GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM**  
**2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201**  
**OR CALL COLLECT: (205) 930-9719 or 9727**



# Infusion By EMT-Paramedics

## State Department of Public Health

### Problem:

Up until late last year, EMT-Paramedics have not been allowed to administer or maintain the infusion of any medications other than those specifically identified on the State approved pre-hospital Physician Medication Order form. This seriously hampered physicians (particularly those in rural hospitals) in being able to transfer patients to higher levels of care because of the frequent nonavailability of nurses to accompany patients in need of fluids or drugs which EMT-Paramedics on the ambulances were not authorized to infuse. The problem persists because it has become apparent that some physicians are still not aware that certain EMT- Paramedics are, or can be, legally authorized to accompany and attend patients receiving many types of drugs heretofore unauthorized for administration or infusion by EMT-Paramedics.

### State Health Department's Response to the Problem:

An emergency amendment to the State EMS Rules was adopted by the State Committee of Public Health in August of 1990. It became effective in regular and final form in December. It permits EMT-Paramedics whose licenses are in good standing to administer or infuse a dramatically expanded list of drugs during interhospital transfers of appropriately stabilized patients, when so ordered by the transferring physician, provided they have documented evidence of having received appropriate training in the new drugs.

### Critically Important Limitations and Considerations:

There are a number of critically important limitations and considerations which must be taken fully into account by all parties concerned when ordering EMT-Paramedics to accompany and attend emergency patients during interhospital transfers. Reference: Code of Ala, 1975, 22-28-1, et seq., and EMS Rule 42-0-2-1-.03(3)(f), Limitations and Authority - Administration/Maintenance of Fluids and Drugs for Stabilized Interhospital Transfer Patients - Appendix D.

a. Children under the age of fourteen may not be administered any of the following medications by EMT-Paramedics under the provisions of this Rule.

b. The fluids and drugs which EMT-Paramedics may administer to adults and persons fourteen years of age or older during interhospital transfers, other than those drugs already on the State approved pre-hospital physician medication order form, are (or their generic equivalents) as follows:

- Vitamin infusions
- Potassium infusions
- Epinephrine infusions
- Magnesium infusions
- Antibiotics
- Procardia
- Procainamide
- Anti-emetics
- Heparin infusions
- Aminophylline infusions
- Dilantin infusions
- Nitroglycerin infusions
- Digitalis
- Analgesics
- \* Thrombolytics
- \* Pitocin
- \*\* Blood products

Note: \* Thrombolytics and Pitocin may only be maintained by the EMT-Paramedic following its administration within a hospital by hospital personnel.

\*\* Blood products may be administered to patients of all ages, including those under fourteen years of age, provided all other conditions are met.

c. A written order containing the following information signed by the transferring physician must be completed and delivered to the receiving facility with the patient:

Patient's name & diagnosis

Name & Signature of transferring physician

Identification of sending facility  
Name of EMT-Paramedic transporting patient  
Name of receiving physician  
Identification of receiving facility  
Date/Time patient released by transferring physician  
Date/Time patient accepted by receiving physician  
Identification of fluids/drugs administered/maintained  
specific medical orders/detailed Rx w/dosages/frequency  
Identification of required life support equipment  
Remarks appropriate to patient management.

d. Medications required by transferring physician should be provided by the transferring facility. All medications/fluids thusly provided for use together with all unused medications, syringes, vials, or empties shall be accounted for by the EMT-Paramedic in the same manner in which the transferring facility normally requires.

e. Documentation shall fully account for all medications administered or maintained during transfer.

f. All medications authorized to be administered or maintained during transfers must be stored, managed, and accounted for separately from those in the normal EMT-Paramedic drug kits for prehospital use, as elsewhere authorized under the State EMS rules.

g. Patients must be deemed by the transferring physician to be appropriately stabilized to permit transport to another health facility by the mode of transport selected.

h. The transferring physician must have explained to EMT-Paramedic all necessary aspects of patient management and the administration/maintenance of the drugs and fluids to be used during the transfer.

i. The only EMT-Paramedics authorized to administer these fluids or drugs during interhospital trans-

fers are those who have in their possession a signed card issued by the EMS division which attests to their having successfully passed the training course, approved by the State Committee of Public Health, entitled, "Administration and/or Maintenance of Fluids and Medications during Interhospital Transfer of the Stabilized Patient."

#### **Further Information:**

If it would be helpful in arranging for interhospital transfers attended by EMT-Paramedics authorized to handle the fluids and drugs mentioned above, physicians should ask the EMT-Paramedics serving their facilities if they are yet individually approved to do so, and should ask them to show their individual authorization card attesting to this fact. If there were ever any question as to an individual's authorization to do so, under the Rules, the physician may telephone the EMS Division on the toll free hotline (1-800-962-9234) to confirm the status of the authorization. If the EMT-Paramedic does not possess the authorization card, has not received the training, the physician should encourage the EMT-Paramedic to contact his regional EMS lead agency or the EMS Division and request that he or she be scheduled to attend the approved training course. There is no fee to be paid for this training. It is available through the regional EMS lead agency.

Physicians wishing more information concerning the medical aspects of this newly adopted procedure should write Dr. Phillip K. Bobo, State EMS Medical Director, Alabama Department of Public Health, 434 Monroe St., Montgomery, AL 36130, or telephone him at 345-2326.



# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

Physician wanted for full or part time work in Private Family Practice in Montgomery. Inquiries to Carol 205-264-6054 Day or Cary 205-281-9974 Night.

For Sale or Lease prominent Family Practice with or without office and equipment. Inquiries to Carol 205-264-6054 Day or Cary 205-281-9974 Night.

VACATION/TEMPORARY COVERAGE: BC/Anesthesiologist and CRNA desire to work locums. Call 1-800-241-7828.

ORTHOPEDIC SURGERY—Louisiana - to be affiliated with highly regarded, well-established orthopedic surgeon. Supported by 212-bed medical center providing a first year net guarantee

between \$200-250K based on experience. Additionally, office rent, business systems augmentation, a nurse, and on-line computer system will be provided at no cost to the first year physician. Finally, practice quality medicine and control your destiny from the inception. Excellent outdoor recreational opportunities. Contact Jim Wiederhold, Lowderman & Haney, Inc., 3939 Roswell Rd., NE, Suite 100, Marietta, GA 30062, (800)486-3020 or use our fax (404)977-6549.

FOR SALE—Salcris Computer System, Unix. 2 printers, 4 terminals, 15 months old. All software updated; licenses and maintenance contract transferrable. Relocating physician. Cost: only bank note due of \$24,500. Call (205)956-1232 or (803)796-3525.

OFFICE FURNISHINGS/EQUIPMENT for sale. Relocating Urologist. Exam tables, secretarial desks, ledger trays, metal chart shelves, new file folders, Xray machine, autoclave, 2 drawer file cabinets, assorted stainless steel instruments, cystoscopes and light sources by Storz. Call (205)956-1232 or (803)796-3525.

FP, IM, GP needed in rural South AL flourishing practice. Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

FPs and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

ER PHYSICIANS NEEDED for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

## SPECIALIZE IN AIR FORCE MEDICINE.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. Find out how to qualify. Call

USAF HEALTH PROFESSIONS  
TOLL FREE 1-800-423-USAF



# The Alabama Impaired Physicians Program

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ◆ *Intervention*
- ◆ *Education*
- ◆ *Guidence to hospital, staff and employees*
- ◆ *Recovery monitoring*
- ◆ *Structured support groups*
- ◆ *Family assistance*
- ◆ *Advocacy*
- ◆ *Liason*
- ◆ *Quality Assurance*
- ◆ *Confidentiality*

***For information call: 1-800-239-MASA or 205-263-6441***  
***On weekends, after office hours and holidays call:***  
***1-205-271-5759***





*Mrs. Stuart K. Bean  
A-MASA, President*

## Dr. James Grotting and Operation Smile

*By Donna Specker  
Media Chairman, A-MASA*

The Filipino teenager was very quiet; others thought she was retarded. But after surgery to correct a severely cleft lip and cleft palate the girl was able to speak for the first time in her life. This modern miracle is only one of many stories of changed lives and renewed hope resulting from the work of enthusiastic people like Dr. James Grotting of Birmingham working with Operation Smile International.

Operation Smile is a non-profit organization which puts together teams of health professionals who visit foreign countries like the Philippines sharing their knowledge and skills. The teams work mostly to correct cleft lip and cleft palate defects for people who have never had surgical care available to them before.

This year Dr. Grotting, a reconstructive and plastic surgeon, will make his fourth trip to the Philippines to the island of Negros. Accompanying a team of 30-35 people he will spend two weeks performing and supervising surgery as well as teaching Philippine physicians new techniques in repairing cleft lip and cleft palate defects.

Dr. Grotting's team in the Philippines will occupy the first three days screening patients and then, according to Dr. Grotting, they will select 130-150 individuals for surgery. For five days they will operate at one of the regional hospitals in the Philippines. "You can imagine the coordinated effort required by the local hospital to facilitate such a tremendous volume of patients in such a short period of time," Dr. Grotting adds. There are typically six plastic surgeons

from the U.S., though the current team includes an Israeli physician. They will spend many hours each day operating as well as supervising Filipino surgeons they have trained at a reconstructive surgery symposium sponsored by Operation Smile.

Dr. Grotting and his wife Ann are residents of Birmingham where Mrs. Grotting is active in the Jefferson County Medical Auxiliary and their church. She has not made any Operation Smile trips with Dr. Grotting because their two sons, now ages five and none, have been too small. Yet Mrs. Grotting has seen through Dr. Grotting what an exciting experience these journeys can be. "When we pick him up," she says, "it's like picking up a kid from summer camp. He's bubbling over with stories."

Most of Dr. Grotting's patients at Negros will have severely cleft lip and cleft palate. Some will be teenagers and adults who have never had medical treatment for these serious and disfiguring defects. "Most families (on Negros) have very little money," he says. "They may have to sell everything they have just to get enough money to travel to the city on the chance that their family member may be selected for surgery." The expressions on the families' faces is one of the most rewarding parts of the trip for Dr. Grotting. "This is life changing surgery for them. Many of the patients will be able to eat solid food for the first time in their lives," he relates.

Like the teenager who had never spoken, many of these patients are denied, by their defect, the chance to associate with the rest of society. Many do not go to school and are reluctant to be seen in public. The impact of surgical intervention can mean dramatic

change in their lives, especially when complimented by work done by dentists on the team who make obturator orthotic device to splint the palate of those who are unable to be operated. Says Mrs. Grotting, "In the U.S. there is always some way to help children with cleft lip. In the Philippines they have so many other basic health problems that there are insufficient resources for non-lethal birth defects. The children often don't go to school. They're self conscious and feel like outcasts. The Operation Smile teams usually do several teenagers but the smaller children are top priority."

Of course it is volunteers who make Operation Smile work. Social workers are included on the team to help screen and counsel patients. Dentists are there to make orthotics and mouth splints, and they bring with them many of the materials that they will need. The team also includes physical therapists and dental hygienists. According to Mrs. Grotting some Operation Smile chapters have high school students involved who raise money for individual projects such as buying a water pump for a small mountain community. Nurses on the team work with local people and instruct the families in wound care since travel for follow up care is financially impossible for many. The team members are "not just a bunch of dogooders" Dr. Grotting says. "They are sensitive to the local community and their needs."

One of the purposes of Operation Smile, Dr. Grotting says, is to work themselves out of a job by training local physicians. And because, according to Mrs. Grotting, there is a higher incidence of cleft lip and cleft palate in the Philippines than in other coun-

tries Operation Smile has also organized a team of genetic researchers to study the problem.

Despite the aura of political unrest in the Philippines the Grottings are not excessively concerned for safety. "You try to be careful," says Dr. Grotting, "but it is not particularly dangerous for civilians." Generally, he says, politics are not so important in the outer provinces, and he feels the unrest is "over-exaggerated."

Dr. Grotting became interested in Operation Smile about four years ago when a plastic surgeon he knew from residency training invited him to go on a trip. "My first response was, 'This is very interesting, but I don't have time.' But he was persistent," Dr. Grotting relates. After one trip he was hooked. "It turned out to be well organized, well done, and geared to the needs of the people," he remembers.

Dr. Grotting believes one reason Operation Smile works so well is because of good organizing by volunteers in the host country. He has worked with the same people in the Philippines over and over. These volunteers spend a great deal of the year arranging for facilities, contacting interested medical personnel and getting the word out to needy patients.

The Birmingham Chapter of Operation Smile is guided by Mike and Sarah Majors. Teams are constantly being formed for missions all over the world including China, Vietnam, Romania, Columbia, areas of Africa and possibly Russia. You may write for information or send contributions to Operation Smile, P.O. Box 9652, Birmingham, AL, 35219. Phone- 205-942-9082.

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and

clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.



# "CHARGE"

*Harold Avant, M.D.\**

The above word was the last command given by George Armstrong Custer. I spent one month on the Little Big Horn reservation of the Crow Indians. It borders on the Little Big Horn river as it traverses lateral to the reservation. This river is known as the Greasy Grass river further south. The Crow Indians appeared to me to be very dependent on the tribal subsidies and had little or no desire to achieve individual success. This tribe had a primitive element that refused to learn or to speak English, therefore, forcing the tribe to provide a dual school system.

The Custer Battlefield is on this reservation and I spent many hours walking the path of Custer and wondering why he charged his troops into 3,000 Indians sequestered in the foliage along the river. Custer had such bad judgment, bad advice, incurable political ambition and omnipotence, that I am sure caused him to risk his life and troops for his own self-serving nature.

Congress is now considering a bill to change the name of the battle field. Congress can change the name but not the history, as they would like to do.

Custer was on orders to clear the area of Indians and to subdue them. These orders came from the White House.

The Wounded Knee episode in S. Dakota was the last assault on Indians by the cavalry and it was ruthless.

Alcoholism is the number one problem among the Crow Indians. There is only the detoxification center with no attempt at recovery or rehabilitation. The number two problem is infection, followed by diabetes, cholecystitis and obesity among the women. I remember the lecture when I was at Tulane Medical school on Tularemia.

The Professor said "this is to inform you about this disease but you probably won't see one case." When I was with the Crow Indians I saw eleven patients with Tularemia. The diagnosis is made by finding lymphadenopathy and by serological testing.

The average duration of the Crow Indian's alcoholic binge is 18 days. He starts drinking at home and after he has beaten everyone in the household he is thrown out. He then proceeds to attack the neighbors until they throw him out of the neighborhood. He then

goes into town, Hardin, Montana, to a bar in the most depraved part of town. He stays there, bumming drinks, starting fights, preying on everyone who passes by, until he is forcibly ejected. At this point he is broke, sick, and without a friend in the world.

If he can scrape together two dollars he will buy a can of Lysol. Lysol is 80% ethyl alcohol. He will drink it, wander out on the plains and pass out. He always goes to the same place because he knows this is where his family knows they can always find him. He will lie there several days and everything that comes by will take a bite out of him, squirrels, rats, prairie dogs, coyotes, snakes, and other Indians. The family would find him and bring him to the hospital. He would then be hosed down, fed, given paraldehyde and sent to the detox center where he would stay five days, do war dances, howl at the moon and assault anyone who got near him. He was then sent home only to repeat the same ritual several weeks later.

The most tragic thing that I saw there was the fetal alcohol syndrome. I delivered one baby with it and you could smell the alcohol on the baby's breath. The mother was a chronic alcoholic. These children have high fontanelles, high cheek bones, and slit-like eyes. They are retarded and hyperactive. This particular baby convulsed on the third day and was air-evacuated to Billings, Montana, to a pediatric intensive care unit.

As far as Custer is concerned, once you hear the lecture by the historians at the Custer Museum, read of his exploits and of his political ambitions, you will realize that only a bureaucrat or a politician could give command to a person of his flawed ability.

As a note of interest, Custer was bald except for the fringe area of his scalp. He let his hair grow long to look as if it were coming from under his hat. He was deathly afraid of being scalped and had the troop shearer to shave his head prior to the battle. This is documented by the shearer who went south with Major Reno to Greasy Grass to act as a flank.

I truly enjoyed this trip. I would have stayed longer but I had practice obligations at home. It is refreshing to break out of your ruts and to enter a different culture for a short period of time.

Project USA puts you in the middle of American history. Mr. John Naughton of the AMA can help you with any question or arrangement.

---

\*20 Croydon Road, Mobile, AL 36608.



# GIVE YOUR MEDICAL CAREER A LIFT.

The Air Force Reserve now offers an **\*affiliation bonus of \$10,000.00 a year** to qualified general surgeons, orthopedic surgeons, anesthesiologists, and nurse anesthetists. Additionally, if you are an operating room nurse, you will qualify for **\$6,000.00 a year**. Affiliation options range from one to three years. Place yourself a cut above the rest by calling the telephone number below or returning the attached coupon.

**\*This bonus is offered in the following states, Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Mississippi, North Carolina, Ohio, South Carolina, Tennessee, and Wisconsin.**

Call: (404)421-4892

**Or Fill Out Coupon and Mail Today!**

To: SMSGT Hartung  
14 AF/RSH  
Dobbins AFB, GA 30069

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Prior Service? Yes \_\_\_\_\_ No \_\_\_\_\_

Medical Specialty \_\_\_\_\_ Date of Birth \_\_\_\_\_

## ***AIR FORCE RESERVE***



# Affordable Term Life Insurance

## from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

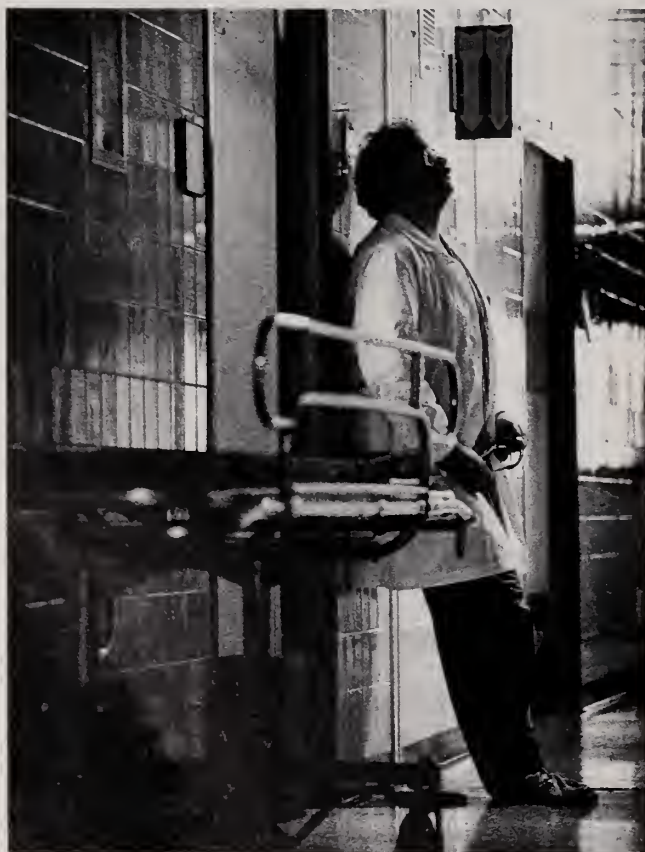
## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

**P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992**

Above rates are provided by Jackson National Life



**"Being a patient advocate is what being a physician is all about."**

Dr. Kevin Fullin, Cardiologist, Kenosha, Wisconsin,  
Member, American Medical Association

Why would a cardiologist get involved in the issue of family violence? Perhaps, because what he saw simply cried out for action.

"Fully a third of all women's injuries coming into our emergency rooms are no accident," says Dr. Fullin.

While others were content to downplay the issue of family violence, Dr. Fullin would not. He petitioned state officials, and through his efforts the first Domestic Violence Advocate Program in his state was created.

"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

The American Medical Association (AMA) couldn't agree more. We're committed to focusing physician attention on the issue of family violence.

Become a member of the AMA today.

Members of the AMA are encouraged to join their state, county and specialty societies.

**American Medical Association**

Physicians dedicated to the health of America



# Your Telephone System May Have a Surprise in Store for You.



Ask yourself these questions, if you want to prevent costly problems.

- **Is your telephone system four or more years old?**

If so, let us show you how prices have come down since then. You may be in an advantageous position to trade, especially when you consider the increased costs of maintaining an aging telephone system.

- **Do you spend more than \$500 a month on telephone services?**

If you do, we'd like to audit your expenses to make sure billing is accurate and costs are in line. There may be several ways to save.

- **Are you planning to move your telephone equipment in the next six months?**

If you are, let us give you a free comparison on moving your equipment or trading it in on a new system with a two-year warranty.

- **Can your present system be modified to handle more calls?**

Very likely. There are new message handling and routing services that could make your system much more productive, without adding to your equipment cost.

- **Did you know there are new rate structures available for business telephone service?**

Absolutely. We'd be glad to discuss them with you to see if any new rates would be good for your business.

Because your business is on the line, call COMTEX today for a free, comprehensive telephone system check.

 **COMTEX**  
INTERNATIONAL  
*A Total Communications Company*  
Birmingham • (205) 871-3000  
Montgomery • (205) 271-4000





The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

A91CA6148T

ONCE  
DAILY **180mg**  
**Calan SR**  
Verapamil HCl  
SUSTAINED-RELEASE CAPLETS

A MILD START IN MILD HYPERTENSION

When diet and exercise alone are not enough...



BRAND A. COUNWAY  
LIBRARY OF MEDICINE  
10 SHATTUCK STREET  
BOSTON, MA 02115-6011

MS

February 1992

Vol 61, No 8

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA



**Dr. Morris's Balkan Genes**

page 10

LIBRARY OF MEDICINE MS  
10 SHATTUCK STREET  
BOSTON, MA 02115-6011

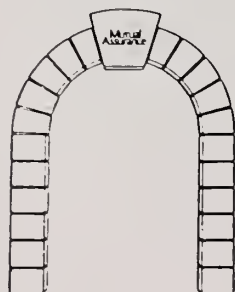


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 8, FEBRUARY 1992

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1992 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Mills, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Joel C. Pittard, M.D. (1992); Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, M.D. (1993), 4th District, Pt. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

## EXECUTIVE DIRECTOR

S. Lon Camer

Secretary-Treasurer - Emmett Wyatt

## DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

THE FRANCIS A. COUNTRYMAN  
LIBRARY OF MEDICINE  
BOSTON, MA

MAY 07 1992

Executive Director.....2

*Product, Process and Medicine*

President's Page.....6

*Stay Attuned*

*Dr. Morris's Balkan Genes*.....10

William H. McDonald

*Self-Medication in Physicians*.....19

Gerald L. Summer, M.D.

Newly Licensed Doctors.....24

Auxiliary.....28

*Dr. & Mrs. James Kimble*

Classifieds.....30

*Equanimity*.....31

Lowell E. White, M.D.

Gordon E. Carroll, M.D.

Jack O. Yeager, M.D.

## Cover:

Peter W. Morris, M.D., the 1992-93 President of MASA, may have been genetically coded to do battle at the disputed borders between medicine and commerce. Page 10.





S. Lon Conner  
Executive Director, MASA

## Product, Process and Medicine

This month's column will attempt to show that medical education and training can be the model for America if this country is ever to regain its ascendancy in world commerce.

With all the protectionist rhetoric in the air this election year, it may sound un-American to suggest that the United States would be well advised to reconsider what protectionism means in today's world. Quite simply, it means that Americans feel industrially inferior to the Japanese and the Germans and are seeking salvation in surrounding our inadequacies with trade barriers and other restrictions on competition.

And what would be the result of that? A perpetuation of inadequacies. That doesn't sound like the America I was brought up to idolize. Boycotting superior technology, by whatever name it is called, has never worked. In the early years of Johann Gutenberg's invention of moveable type, which occurred about the time of the discovery of America, the European monastic orders were threatened by technological unemployment. Until that time, they had a monopoly on transcribing manuscripts, the laborious and slow process of hand-copying by scribes.

Books were therefore extremely rare and very expensive. Herr Gutenberg's invention in the early Renaissance (which was given one of its primary boosts by that invention) was catastrophic for the monastic monopoly. Not only had the new printing process made the reproduction of books cheaper and

more widely available, it democratized them in other important ways. For example, church censorship of taboo discussions (such as the blasphemy that the sun, not the earth, was the center of our corner of the universe) would be much more difficult with the laity's release from monastic control of information and ideas.

Although the power of Rome was such that Paris was denied the benefits of the new technology for 25 years, while Parisian monks continued to copy books by hand, in the end the new technology won out, as it always has before and since.

The industrial revolution in the 18th and 19th centuries produced a new kind of resistance to technological change, this time from the masses. Between 1811 and 1816, for example, roving bands of enraged workers in Britain destroyed new knitting machines, cotton power looms and wool shearing machines that were displacing human hands and thus causing unemployment.

Many of these sabotage raids were carried out in the name of the mythical Ned Ludd, also called King Ludd, whence comes our word *luddite*, for someone who blindly opposes technological progress. We see luddites at work all over the nation in 1992, smashing Japanese cars with sledge hammers—all in the spirit of old Ned Ludd: emotionally satisfying, perhaps, but as pathetically futile as in the early 19th century.

It is not the *product*—automobiles—that is being physically attacked, because we make cars too and once led the world in them. It is the *process* by which



# SYSTEMS CORPORATION

Independent Medical Systems Consultants

*At SYSTEMS CORPORATION, we believe that computer systems should do what you pay them to do. Quietly, unobtrusively, and profitably.*

*We believe appropriate selection of software, correct installation, informative training and open-ended availability of our assistance, coupled with your commitment, will result in a successful system.*

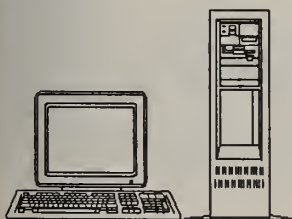
*Yes, we are in business to make money — by making you money through well considered recommendations of software and hardware for your medical practice. As consultants, we are at liberty to recommend the very best choices to you — the payor of our fee. We can assist you with your present system or assemble a new well-rounded computer system based on evidence pertinent to your practice.*

*And guess what? We will obtain for you wholesale — or near wholesale — prices for every product we recommend.*

*What should you expect from your practice management system?*

- *Comprehensiveness — before buying, be sure that a system has been well designed, well tested, and is in widespread use throughout the United States. Proprietary (home-grown) systems are simply unacceptable.*
- *Controls — so you can know that your practice's revenue system is working for you and that it requires your employees to do the same. This can mean real money in your pocket.*
- *Electronic Billing — so you can expedite your practice's cash flow and reduce billing costs.*
- *Expandibility — so it is unlikely that you'll ever outgrow your system's capabilities.*
- *Customization — so that you can add special features you desire, such as medical histories accessible by you when you are not in your office.*

*As highly trained specialists, we will earn your trust — and our keep. Next time you have these kinds of things in mind — no matter the size of your need — won't you see what we can do for you?*



SYSTEMS CORPORATION  
1-800-239-1717  
Suite 2108, First National Bank Building  
Mobile, Alabama 36602  
(In Mobile, call 432-1313)



the Japanese have reverse-engineered the automobile to produce high quality at a lower price.

Right there is the essence of the problem — *process* development and product development — wherein America's challenge lies.

Lester C. Thurow addresses this in a book to be published in April: *Head to Head: Coming Economic Battles Among Japan, Europe and America*. A theme chapter was reprinted in *Harper's* for March and it is from this that I will be quoting.

Prof. Thurow, Dean of the MIT—Sloan School of Management, notes that in the past the nations that succeeded economically were those whose businesses invented new products: "The British in the 19th Century and the Americans in the 20th Century got rich by doing this." But, he warns:

"In the 21st century, sustainable competitive advantage will come not from new-product technologies but from new-process technologies — those that enable industries to produce goods and services faster, cheaper and better."

American firms, he writes, currently spend two-thirds of their R&D money on new products and one-third on new processes. The Japanese do exactly the opposite — one third on new products, two-thirds on new processes.

Our investment strategy is, he says, about 30 years out of date. In the 1960s the rate of return on investment in new-product R&D was almost always higher than that on new-process R&D. A new product gave the inventor the monopoly power to set higher prices and earn higher profits. With a new product, there were no competitors. In contrast, "a new manufacturing or production process left the inventor to fend for himself in an existing, competitive business. Competitors also knew how to make the product, and they would always lower their prices to match the inventor's. It was simply rational to spend most of a firm's money on new-product development."

That is the course we followed, and the money flowed in, while Japan and Germany focused on process technologies. They did so because in the aftermath of World War II they had no choice. Untouched by war, our industrial advantage in new products was so great it was virtually impossible, Prof. Thurow writes, for either Germany or Japan to become leaders in product development.

Their only hope lay in existing markets. Both countries began pouring money into process R&D.

As it happened, the short end of the stick became the long end. Process, not product, is now king. Examples of Japanese ingenuity in using process to

get rich are the three most successful products in the consumer market in the past 20 years — the VCR, the fax, and the CD player. Americans invented the first two; the Dutch, the last. Japan made all the money in sales by reverse-engineering, developing ways to produce them both cheaper and better. For all practical purposes, all three of these products are now considered Japanese.

Forced by economic circumstances to learn how to make things cheaper and better, the Japanese and the Germans now possess the right R&D strategy for the foreseeable future, Prof. Thurow argues. To catch up, it's not enough to smash Toyotas or to try to intimidate Americans into buying only native products. What is needed, Prof. Thurow believes, is nothing less than another industrial revolution in the U.S. And it should be a revolution at all levels.

Production is not prized in the America of the 90s. Only 4% of American CEOs come from production; the best and the brightest have avoided processes; manufacturing ceased to be taught in most of America's major business schools. Manufacturing — that is, process — has become almost a dirty word to those aspiring to become captains of industry. That's for the blue collar set, not for a gentleman or gentlelady of breeding.

By contrast, in Japan and Europe, the top brass is overwhelmingly the technically educated; the route to the top is usually from the factory floor. In this country, the factory is a dead end for the ambitious.

As a consequence of this trend, the pay and promotion curve for American managers and engineers in production has fallen far behind those in other parts of a firm. These career tracks are avoided by superior people, men and women alike. As a result of all this wrongly placed emphasis, America has fallen far behind in new-process technologies. Prof. Thurow cites a striking example:

"Twenty-five years ago the leaders of the American steel industry failed to comprehend the technology revolution that was under way and chose not to make the massive investments in oxygen furnaces and continuous casters being made elsewhere in the world. American steel companies have been playing an unsuccessful game of catch-up ever since."

Now and on into the 21st century, Prof. Thurow writes, there will be high-tech and low-tech products but almost all will be made by high-tech processes. Example: the automobile is a low-tech product but the robots that make it are high-tech. Gaining an edge in high-tech processes will be important in everything from fast food to textiles.

He cites an example of what American planning can do: The Limited, a clothing retailer, uses high-tech inventory control, telecommunications and CAD-CAM (computer-aided design/computer-aided manufacturing) to determine what women are buying and to put these precise clothes in the stores within 28 days of spotting a trend. Competitors still need six months.

The neglect of process is seen in many other problem areas in the country, particularly in the decay of schools. If all we had to do to succeed internationally was to invent new products, it would be enough to give the best educations to the smartest 25%, Prof. Thurow says. But when success depends on being the cheapest and best producer of products, the education of the bottom 50% of the population becomes critical. "If the bottom 50% cannot learn what must be learned, new high-tech processes cannot be employed," he says.

Which, finally, brings me to my point: with so many shortfalls in American goods and services, one sector always stands out as a model for all nations — medicine. By international consensus, it remains the world's best.

Why? The education of physician has remained long and exhaustive by a continuing commitment to quality process. New products, from antibiotics to MRI, come along with great rapidity but they are quickly put into efficient use because the medical process has been so thorough that no new technology stumps the profession for long.

I am not, of course, suggesting anything approaching the intensity of medical education for the American masses. But unless and until our schools can produce thousands upon thousands of young people with basic skills in math, science and communication, no amount of hypereducation of the elite 25% will do much to restore America's place in the sun.

**AIM  
HIGH**



## CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

**USAF HEALTH PROFESSIONS  
TOLL FREE  
1-800-423-USAF**







*William D. Lazenby, M.D.  
President, MASA*

## Stay Attuned

Some physicians, I fear, believe that it is sufficient for their involvement in organized medicine's many concerns if they are willing to trust one of their number to represent them on the Board of Censors, the AMA delegation, etc. Having turned the job over to "good old George," they figure that's about all the participatory democracy they need.

While that expression of trust is appreciated, it won't cut the mustard these days. The complexity and rapidity of new challenges can overwhelm good old George too. After all, he has the same practice demands as you, the same office problems, the same family responsibilities, the same need for a little time away from the pressure once and a while.

Perhaps as recently as 10 years ago, George could have done it alone, without your input. But back then the time required to read all the background information on new issues and challenges was a fraction of what is required in 1992.

Take the Board of Censors, for example. Our board-books each month get fatter and fatter with material. And still more information is piled before us all during our two-day deliberations. The agenda may look relatively short but the complexity of each item seems to have expanded exponentially in recent years.

For one thing, there are no isolated issues these days. Everything seems attached, however tenuously, to everything else. There are so many variables in the air at once, we often wish we had recalled more of those "differential equations" we sweated through long ago. Not only does everything seem interrelated, but nothing stays in one shape long enough to

draw a bead on it. The situation, as the generals used to say in World War II, is fluid.

I was reading something just recently about a relatively new technique of networking a few dozen ordinary personal computers to solve extremely intricate problems. As I understand it, these relatively simple machines, once joined in common cause with dozens of others, are as powerful as one of the mighty supercomputers. Each alone has little capacity for the problem. But by networking them, each simple PC takes a piece of the problem and the product of dozens of them working as a team is awesome. I like the obvious analogy.

Each of us has finite limitations on our time and our capacity to give long hours of study to some of the more demanding issues of the day. But by networking our thoughts, we can square and even cube our total capacity. I am saying that 5,000 heads of Alabama physicians may sometimes be better than the 15 on the Board of Censors. And if we ever needed all of those 5,000, we need them now.

It is not enough that your chosen officers in the state, or nationally, address the problems. You don't free yourself of personal responsibility to your profession when you pat George on the back every year or so and tell him he's doing just fine. If medical practice as we know it is to survive, it is going to require the constant, intense thought of all physicians.

Jot down your thoughts and send them to one of those who represent you. Don't suppose that just because you thought of it, it must have long ago occurred to George. It may not have; after all, he's swamped with material. Jot it down, no need for a

## ON INVESTING — TRUE OR FALSE?

T F

- ☒ ☐ Bears make money. Bulls make money. Pigs get eaten.
- ☒ ☐ The historical, average net profit earned from investing in stocks in this country approximates 10% per annum.
- ☒ ☐ The usual effect on a portfolio from the actual loss of principal is more serious than the loss of potential profits.
- ☐ ☒ Risk is usually evident in any investment and is easily understood.
- ☐ ☒ Rates of return are usually calculated the same way by most financial professionals.
- ☐ ☒ Expenses paid by you (such as commissions, trustee's fees, etc.) to achieve returns should not be taken into account when calculating your rates of return on investments.
- ☒ ☐ Inconsistency in rates of return is more typical than not and is damaging to the growth of your assets.
- ☐ ☒ Selling too soon is a sure way to do poorly.
- ☒ ☐ Flexibility — and the ability to change investment positions quickly — if necessary — at a minimum of expense — if any — is essential to consistently achieving above average rates of return.



### INVESTMENT ADVISORY & MANAGEMENT CORPORATION

Suite 2110 First National Bank Building  
Mobile, Alabama 36602

1-800-239-1666  
In Mobile (432-1666)

Our stated objectives to every client are to:

- (1) Make our best efforts to consistently achieve at least a 10% per annum rate of return on all money entrusted to us — net of all expenses we are allowed to control — year after year after year.
- (2) Safeguard all money entrusted to us as principal. We endeavor to maintain principal in foundation type investments which generate funds for somewhat more aggressive investments.
- (3) Represent you — and no one else.

For further information as to what we do — and how we might be of assistance — please contact us.

Registered Investment Advisor  
With the U.S. Securities Exchange Commission and The States of Alabama and Mississippi

This document is proprietary and confidential information of Investment Advisory & Management Corporation. Copyright applied for.



formal letter, and send it to him. Or call him. Or buttonhole him in the doctors' lounge.

Times have changed in other ways as well. Some years ago, when a challenge impended, there was often time to think about it for a few leisurely weeks, send out a few paragraphs of material to a couple of trusted colleagues, then wait a few months for their response, if any.

No such luxury exists today, when issues seem to have a half-life of about 10 days. The 30 days between regular monthly meetings of the Board of Censors can seem an eternity, as time is reckoned in the brave new world of medical socioeconomics. That accounts for the number of conference calls to the Board of Censors during the year.

Stay informed as events unfold. An excellent source of topical information is *American Medical News*. If you read every issue thoroughly, you will have at least the background comprehension of, say,

new dispensations from Washington. News of health care developments in other states may not be as remote from your own concern as you think. Tomorrow that same thing could be happening in Alabama.

The same information age that has produced quantum leaps in our understanding of the human body and its ills has also vastly expanded and accelerated the flow of political events.

We have all the brainpower we need, if we can somehow cable it together.

In summary: stay informed about every aspect of local, state and national events that may bear on American health. Read for at least a few minutes every day. Stay abreast of the news. When a crisis comes, it will be impossible to catch up. I know, I know — you have clinical reading to do. We all do.

George needs you perhaps even more than you need George. Help him.

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

**P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992**

Above rates are provided by Jackson National Life



They took little sticks and touched me. It felt like a dream.



"A dream" is how Sandi Fornea described the nightmare she thought she'd never wake up from. A cheerleader and campus beauty who seemed to be living a charmed life, she felt her body gradually go numb from a rare virus. The way Sandi saw it, her paralysis had changed her whole life for the worse. And that's when the staff at

MMRC set out to change her mind.

"They respected me," said Sandi. "They didn't patronize me or treat me like a child. They taught me that if you believe in yourself, you're okay."

Sandi's illness opened her eyes to the fact that there are thousands of people like her, and made her want to do for others what the staff at MMRC had done for her.

Teaching others to believe in

themselves is what rehabilitation is all about. It's what makes MMRC the South's leading rehabilitation center.

Just ask Sandi. Today she's fully recovered, and studying to be a physical therapist.

And she'll probably tell you it feels like a dream.



1350 East Woodrow Wilson, Jackson, MS 39216  
(601) 981-2611 or 1-800-223-6672



# Dr. Morris's Balkan Genes

*William H. McDonald*

Most physicians, it seems fair to say, would not voluntarily place themselves at the fractious interface between medical practice and the health care business.

For it is there, after all, that most of the controversies between third parties and doctors occur, often generating more heat than light. As the yuppies were once fond of saying, that's where the rubber meets the road.

All the more reason that friends, colleagues and admirers of Peter William Morris, M.D., cannot figure out why he has so often positioned himself at this very juncture, where the bones of contention are gnawed.

You would think that, after almost 30 years of practicing internal medicine (hematology/oncology) in Birmingham, Dr. Morris would be more attracted to ancillary pursuits offering peace and tranquility.

Anything but. Wherever there are points of friction in the ongoing health care debate, Dr. Morris seems to be on the scene or nearby. Consider: he has risked unpopularity among his colleagues as chairman of the Utilization Management Committee of St. Vincent's Hospital in Birmingham for the past seven or eight years; before that, he served on the hospital's old Utilization Review Committee; he has been a Board member and president of AQAF; not least, he has been a member of the Board of Censors, itself no stranger to controversy; he is a member of MASA's Third Party Grievance Task Force and the Board of Medical Examiners; and he will serve as the Association's President 1992-93 at a time when all hell is breaking loose.

Not even the last office is free of angst for its inhabitant. Some MASA Members blame their President for every ill wind, of which there have been

more than a few in recent years.

Most recently, Dr. Morris has been involved, at one level or another, in two advanced concepts of medical review, in which Alabama has been selected as a pilot project — the Uniform Clinical Data Set, which at this point takes too much time to be practical, though it holds promise for the future; and DEMPAC (for Developing and Evaluating Methods to Promote Ambulatory Care Quality), which describes its ambitious mission even though it is a long way from practical application. Both are HCFA pilot projects of AQAF, which has already had an ameliorating effect on some of the more draconian methodologies advanced by Washington.

In his acceptance of none of the above jobs, in fact, can Dr. Morris be accused of seeking the easy way, of letting George do it. Physicians are familiar with the clarion call from their chosen leaders to "get involved." Dr. Morris, who marches to a faster drummer, heeded that call long ago. He believes that only by participating in the formation of new concepts can physicians change, deflect, or moderate their application. Those who are content to stand on the sidelines and bellyache do a disservice to themselves, their colleagues and their patients, Dr. Morris believes. Only by coming to grips with challenges, in hand-to-hand combat, can the medical profession hope to affect policy, he holds.

As persuasive as that may sound in theory, some would say it still does not explain the sheer number of thankless front-line jobs Dr. Morris has volunteered for. Why does he inflict such pain on himself? This being an election year, when the motivation of scores of candidates will be systematically questioned, it seems timely to speculate on why Dr. Morris seems to



## Pain relief for providers that's easy to swallow.

If your practice is like most, filing insurance claim forms and waiting for eligibility information is a major headache. The problem is, it's a slow, manual process which can restrict your cash flow. And that's painful for any business.

BellSouth Corporation and Blue Cross and Blue Shield of Alabama have a simple prescription for this really BIG headache: The BellSouth *Electronic* PPO.

If you are a provider servicing BellSouth employees and filing claims to Blue Cross and Blue Shield of Alabama, you may qualify to join the *Electronic* PPO program and:

- **STOP LOSING REVENUE** for services rendered on NON-eligible patients
- **Transmit ALL** claims accurately and electronically
- **Receive claims payments faster**
- **Verify insurance coverage electronically**
- **Identify pertinent waivers and restrictions**

So, if your practice suffers from sluggish cash flow and the pain of overwhelming insurance paperwork, **call 1 800 225-5056** for relief.



# **BELLSOUTH**



gravitate to trouble spots.

The present writer's guess: Dr. Morris was genetically coded to be where the action is, and those genes came from his late father, William K. Morris.

The elder Morris immigrated to this country from Greece in 1910, finding railroad work in Illinois. In 1912, however, he returned to Greece to fight in the Balkan Wars, two short conflicts (1912-13) fought over the possession of the European territories of the Ottoman Empire.

Despite the 1913 Treaty of Bucharest, the Balkan Wars prepared the way for World War I, in which Mr. Morris also fought. The Russian Revolution of 1917, which overthrew the czarist government, gave him yet another war to fight, this time against the Bolsheviks. But by 1920 he was ready to beat swords into plowshares; he returned to the promised land. In that year he joined a brother already living in Birmingham. In 1925, he married a Greek lady from Charleston, S.C. They had four sons; Peter, born in 1930, was the second.

The elder Morris owned and operated Paramount Barbecue, on Birmingham's Southside, from 1925 until his death in 1964. He wanted more for his sons than the restaurant business, he often told them, singling out Peter to be a physician, despite the younger Morris's proclaimed desire to be an accountant. Finally, sometime in high school, Peter's defenses against his father's entreaties began to crumble.

Dutifully, he entered pre-med at the University of Alabama but his doubts about his destiny as a physician were at first rekindled by the complexities of his major, biology. By his junior year he was totally committed, however, and there was little doubt about his fitness for medical school; he went on to make Phi Beta Kappa, no mean feat in any course of study but particularly notable in biology.

Young Morris came to understand his father's ambitions for his sons; they would be the living proof of a Greek immigrant's accomplishments in the new world: the American experience writ large. None let his father down. Final score: two physicians and two engineers.

To a layman, it seems likely that the genes that drove their father through eight years of the misery and squalor of war in Southern Europe were passed on to the sons. Was this the genotype that pushed Peter W. Morris, M.D., into the battle zones of what has been called the Balkinization of medical care? (When Dr. James D. Watson completes his mapping of the human genome, there may be stronger grounds for such speculation.)

It is, in fact, this Balkinization of physicians into factions, each with its own agenda, that bothers Dr. Morris most as he contemplates his presidential year.

"I believe the biggest problem in organized medicine — on both the state and national levels — is in finding a common ground for all of us, all specialties, to work together," he says.

"Unless we can truly present a united front, government and other third parties will run over us. Our strength is the strength of numbers. We either hang together, as one of the signers of the Declaration of Independence said, or we will hang separately."

*Question: But you will acknowledge, won't you, that in the pluralism that is organized medicine today, the various disciplines do have different problems? And that sometimes the apparent solutions to these problems are in conflict between the specialties?*

A. "Of course. But the concerns that should unite us are for more important, for our patients as well as ourselves, than the concerns that may divide us. I happen to believe that we can work out such conflicts as do exist if everyone is prepared to make reasonable accommodations. We will have to make compromises; that, after all, is life."

*Q. As a follow-up question, do you believe there has been any recent evidence that physicians are becoming more interested and involved in issues and solutions in recent years?*

A. "Absolutely. There is no question that doctors are taking more interest in what is going on. That has happened in the last two or three years particularly. Before, many of them didn't care at all. 'Leave me alone to practice medicine,' was a common response to appeals to enlist their interest. More and more, I believe, all physicians are coming to the realization that all the challenges and changes will have a major impact on how they practice medicine. You can't practice in splendid isolation any more."

*Q. One of the problems of a few years back was that too many physicians weren't really informed on all the details of the issues of the day. Has that changed as well?*

A. "Unquestionably. I have often been surprised recently by the depth of knowledge I encounter among physicians on issues. And some of the best

# FREEDOM FROM PAIN!

Extra strength pain relief  
free of extra prescribing  
restrictions.

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

## Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2:379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

## The heritage of VICODIN<sup>®</sup>, over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin** **ES** 

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

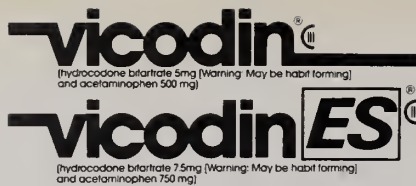
Tablet for tablet, the most potent analgesic you can phone in.

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit





**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

**WARNINGS:**

**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**PRECAUTIONS:**

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

**Usage in Pregnancy:**

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:**

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphonia, psychomotor dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

**DRUG ABUSE AND DEPENDENCE:**

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

**OVERDOSAGE:**

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989

Knoll Pharmaceuticals  
A Unit of BASF K&F Corporation  
Whippany, New Jersey 07981



5864

BASF Group

informed seem to be those who were saying 'leave me alone' just a short time ago."

*Q. How do you account for this change? Is it a kind of fatalism or is it realism?*

A. "Oh, I think it is definitely realism. Fatalism was what they had before, the feeling that they couldn't have any effect on change so why worry about it? Now they know they can make a difference sometimes. And even when they can't, they need to know all about new developments as they evolve. You know, it's easy to get lost if you don't keep up. Trying to catch up after missing the first part of a continuing controversy can be almost impossible sometimes."

*Q. Can you cite an example of involved physicians making a difference in, say, Washington?*

A. "The most obvious example is last year's fight over the Medicare conversion factor. The bureaucrats, probably led by Richard Darman, tried to use the conversion factor as a budget-cutting device when all parties had agreed in advance that this would not be done, and Congress had so ordered. We had a good case, we hit Congress and HCFA with thousands of letters, as AMA had requested, and we mobilized congressmen of both parties to support our case. And we won back most of the cut. But, remember, this was a strong case of Washington's breaking a promise. It's not always that cut-and dried."

*Q. In your work as chairman of a hospital Utilization Management Committee have you seen a change in the attitudes of fellow physicians?*

A. "When we started this seven or eight years ago, I was the enemy. This was a very unpopular function. Doctors were unhappy and I was never really sure that the hospital was behind us all the time either. We were, in a sense, working against the hospital. For a long time we were spinning our wheels trying to educate the staff to admit prudently, to discharge on a timely basis and to order only what was necessary. In those early days, the hospital was losing money on what we did. But when prospective payment and DRGs came in, we were saving the hospital money, since you get paid the same amount whatever you do.

"In my hospital we have other committees that are more concerned with quality of care and they were really unpopular. More unpopular than my commit-

# The Alabama Physicians Recovery Network (PRN)

***(Formerly Impaired Physicians Program)***

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ◆ *Intervention*
- ◆ *Education*
- ◆ *Guidence to hospital, staff and employees*
- ◆ *Recovery monitoring*
- ◆ *Structured support groups*
- ◆ *Family assistance*
- ◆ *Advocacy*
- ◆ *Liason*
- ◆ *Quality Assurance*
- ◆ *Confidentiality*

***For information call: 1-800-239-MASA or 205-263-6441  
On weekends, after office hours and holidays call:  
1-205-271-5759***



tee. Quality committees would ask doctors, why did you do this, why didn't you do that? and there was a lot of animosity, but that has subsided. There are still controversies, of course, but they are not as heated as before."

*Q. Going from the more or less sublime to the more or less ridiculous — this is a presidential election year and the bidding war on national health insurance is already well under way. What do you think about this issue and its survival chances into the general election in the fall?*

A. "Unquestionably, this will be a big issue. Bush realized this after Dick Thornburgh lost in Pennsylvania last November at least partly because he didn't have a viable answer to his opponent's demands for some form of national health care. But I don't believe Bush's plan will fly. The people think we have all this money from savings in defense spending and a national health care plan would be a good investment for those savings.

"Of course, the peace dividend is largely a myth since it was all debt anyway, not billions of dollars of cash we now have lying around waiting to be used. But the public perception is that now that communism has collapsed we can turn to what a lot of people think is the number one domestic issue, some form of universal health plan. I doubt that Bush can sell his very limited approach. It really is just a Band-Aid because it relies heavily on managed care. We've tried managed care for the last 10 years and it doesn't help overall. About all it does is to shift where the money goes. The Democrats will push for universal health insurance, not socialized medicine as such,

"Personally, I would favor some form of universal health insurance as in the model offered by AMA. If you do insure everybody one way or another, there will be no cost shifting. And the money we won't be spending on defense — or the debt we won't be incurring for that purpose — could be diverted to this use. At least that is the public's expectation."

*Q. But does anybody really know what the public thinks about this? Polls show that everybody would like to have free medical care, but if a federal program is going to cost them anything substantial, the support plummets.*

A. "If you go to universal health care, somebody has got to fund medical care for everybody, if that's what the American people want. If they want it,

they've got to pay for it. I saw a poll just last night that reports that 55% of the patients interviewed were satisfied with their medical care. But then 95% of the same group thought there ought to be changes. It just doesn't make any sense. One thing they had better remember is that they had better not mess up the 85% of the people getting the care they need for the 15% who aren't. You don't want to bring down the care for the many to provide for the few."

*Q. Following that up, don't you think politicians, particularly presidential candidates this year, are responsible for much of the public confusion? After all, these are the people who keep telling the public that their particular plan will be painless, no new taxes on anybody except maybe the rich. Hasn't there been a massive failure of public accountability by politicians?*

A. "I think there has been such a failure. But I also think there has been a failure on just about everything having to do with federal revenues and expenditures. Most Americans think there are uncounted billions lying around in Washington waiting to be claimed. With rare exceptions, both parties in both houses of Congress are culpable in this regard. They won't level with the public, possibly because they believe that the public doesn't really want the awful truth. In any case, it is a very confused picture. And the confusion is reflected in public opinion polls."

*Q. What bothers you most about the way medicine is already being practiced, possibly because of the pressures of third parties, managed care and the rest?*


A. "Well, a lot of things bother me but let me tell you something that happened in my own family just recently: My wife called her mother's doctor to make an appointment. The doctor's office told my wife that they must have her mother's account number before an appointment could be made. My wife did not know the number or that one existed. Finally, after considerable discussion, the doctor's office grudgingly agreed to make an appointment, but warned: 'Next time, you'll have to have a number before we will make an appointment.'

"I thought, 'My God what have we come to? You can't make an appointment unless you have a number.' Because it won't work in the damn computer. [Dr. Morris, normally pretty calm, is visibly angry.] They don't go by names any more; they go by number. Absolutely ridiculous! What if you do have more than one Mary Joneses? Pull the charts on all of them!



# Your Rx for Valium

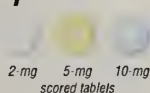
(brand of diazepam/Roche)



may be open to  
seventeen  
interpretations...

unless you settle the issue by signing  
on the "Dispense as Written" line.

**VALIUM**<sup>®</sup>  
brand of  
*diazepam/Roche* <sup>IV</sup>



*The final choice should really be yours*

The cut out "V" design is a registered trademark of Roche Products Inc.  
Copyright © 1991 by Roche Products Inc. All rights reserved.

ROCHE

**Roche Products**

Roche Products Inc.  
Manati, Puerto Rico 00701

\*According to the Orange Book, 10th ed, US Department of Health  
and Human Services, 1990, diazepam tablets may be available from as many  
as 17 companies. Tablets shown represent 5 mg diazepam tablets.



My God!"

Dr. Morris was graduated from the UAB School of Medicine in 1956. After his medical internship at University Hospital 1956-57, he served two years in the Navy, much of that time aboard ship out of Norfolk. After his sea duty the base commander asked for his medical preferences at the base dispensary. "Anything but pediatrics, sir," Dr. Morris replied. ("I really knew little about pediatrics," Dr. Morris says in telling the story.)

Physicians with service experience can easily guess what his dispensary assignment was... Right, pediatrics, for the nine months remaining in his service obligation. In fact, for the entire length of his service, at sea and ashore, he was never assigned any medical duties of the kind he had been trained to perform, such being the logic of military placement.

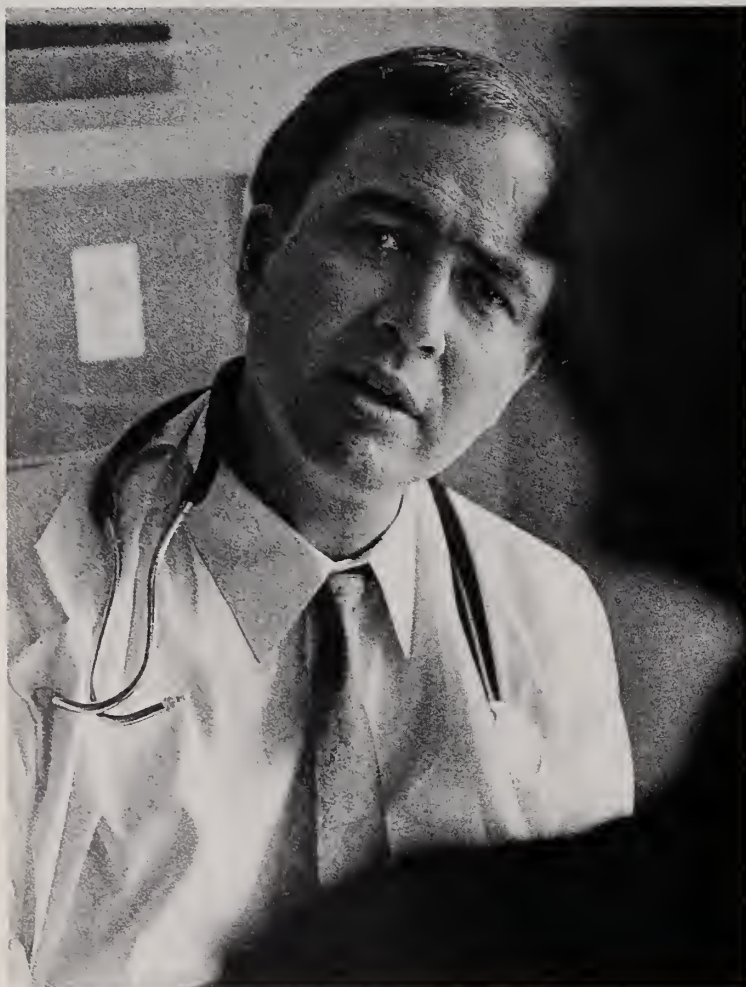
After the Navy, Dr. Morris served his medical residency at University Hospital, Birmingham, 1959-61, followed by a two-year fellowship in hematology and oncology at Duke University Hospital, Durham, N.C.,

1961-63. He chose his internal medicine specialty because at the time his hero was Dr. Tinsley Harrison, and the hematology/oncology subspecialty because during this period "they were just beginning to treat leukemias, and the work was very exciting." Cardiology, by contrast, "was still pretty primitive: they didn't have intensive care units, catheterizations, and all that. Most of those who came in with heart attacks died."

Dr. Morris and his lovely wife, Diane, have two grown children.

Association members will be well served by the presidency of Dr. Morris, whose socioeconomic experience at the turbulent margin between medicine and business has been broad and deep. He is very well read in current affairs. He is a good listener, but shaky premises and weak argument don't pass muster with him. He neither minces nor wastes words. Like his soldier father before him, Dr. Morris thrives in the trenches.

It must be, it can only be, those genes.



**"We must make sure that policies are based on facts, not fears."**

Dr. Paul Volberding, Researcher, University of California, San Francisco, Member, American Medical Association

Amid the rancor of politics and budget debates, the needs of the patient are often overlooked. And, it is forgotten that it is physicians who know the most about disease and the suffering of patients.

Nowhere is this more true than with AIDS.

"Throughout the history of epidemics, there has been the possibility of reactions and policy based on fear and stigma," states Dr. Volberding.

The American Medical Association (AMA) agrees. The AMA is committed to fair AIDS policies, and to supporting researchers battling not just AIDS, but the countless diseases that ravage our society.

"What impresses me most about the AMA is its willingness to take public policy positions and its ability to influence opinion," Dr. Volberding adds.

Become a member of the AMA today.

Members of the AMA are encouraged to join their state, county and specialty societies.

**American Medical Association**

Physicians dedicated to the health of America



# Self-Medication in Physicians

*Gerald L. Summer, M.D.*

*Medical Director, MASA Physician Recovery Network (PRN)  
(Formerly, Impaired Physicians Program)*

Self-medication by physicians has been recognized yet sufficient attention has not been given to the dangers involved. Physicians treat themselves more often than they use drugs recreationally.<sup>1</sup> Self-treatment for physical illness or emotional stress may be fraught with serious consequences as the following two case histories reveal:

**CASE 1.** A 47-year-old family practitioner had a history of hypertension and a coronary bypass in 1988. He was reported to the Alabama Impaired Physicians Program [now PRN] because his behavior suggested chemical dependence. When referred for inpatient evaluation, he indicated he was taking (self-prescribing) Lopressor (Metoprolol) 500 mg a day, Prozac 20 mg daily for depression, Ativan (Lorazepam) and Dyazide (Hydrochlorothiazide), 2 capsules daily. Initial testing revealed mental confusion and depression and a severe deficit in his initial full IQ testing. The Prozac, Ativan and Dyazide were stopped and the Lopressor reduced to 200 mg daily. Ten days later, his IQ was increased significantly, confusion resolved and depression greatly improved. No evidence of chemical dependency was found. He currently has a primary care physician managing his medical problems and is a productive physician in his community.

**CASE 2.** A 48-year-old family practitioner described abusing alcohol for several years. He attempted to reduce use for fear of discovery. Uncomfortable withdrawal symptoms developed, which included anxiety, insomnia and tremors. He discovered that opiates could temporarily relieve these uncomfortable feelings. He began taking Lorcet

(Hydrocodone 7.5 mg), and experienced rapid progression of tolerance over two years until he was taking 40-60 tablets daily. Loss of control was evident when compulsive use of opiates continued despite the adverse consequences of deteriorating family dynamics and medical practice. He reluctantly entered a treatment facility early in 1991. Response to treatment was poor. He left treatment against medical advice and attempted to manage his own recovery program. Subsequently his license to practice medicine was temporally suspended by order of the Medical Licensing Commission of Alabama after an administrative complaint was filed against him by the Alabama Board of Medical Examiners alleging violation of Code of Alabama 1975 by self-administration and use of controlled substances to the extent that he was unable to practice medicine with reasonable skill and safety to patients. He is currently in outpatient recovery groups making positive steps toward sobriety and anticipating regaining his license to practice medicine.

Both cases reveal the inherent danger in self-medication. Case 1 clearly illustrates impairment as a result of self-treatment for physical illness. Complications of the drug taken resulted in mental confusion and depression to the extent that aberrant behavior became evident resulting in referral to the Alabama Impaired Physicians Program [PRN]. Case 2 illustrates the problems of self-medicating uncomfortable feelings. Once the addictive process was in effect the physician had no control and used increasing doses of opiates continued despite adverse consequences. In both cases the physician failed to recognize the relationship between self-administered medi-





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association

cation and progression of symptoms.

The danger of self-prescribing psychoactive drugs in physicians has been studied. In a comprehensive study of surviving relatives and friends of 142 physicians who died by suicide, more than half (56%) had prescribed psychoactive drugs for themselves.<sup>2</sup> In a matched control group of physicians who died of causes other than suicide, one-fifth (22%) prescribed psychiatric drugs for themselves.<sup>2</sup> In a larger study of practicing physicians and medical students, self-treatment most often involved tranquilizers and opiates.<sup>1</sup> One-fourth (25%) of physicians had treated themselves with a mood-altering drug during the previous year. In state impaired physicians programs, more than three-fourths (75%) of participants self-medicate and this does not include antibiotics.<sup>3</sup>

Physicians self-medicate for a variety of reasons. It is very easy for a physician to take psychoactive drugs to relieve anxiety, insomnia or to feel "normal." Physicians have access to drugs not readily available to the general population. Pharmaceutical samples assure them of that. The Physicians Desk Reference does not reveal true dependency characteristics of benzodiazepines in the 10-20% of individuals who may be susceptible to progressive addictive disease. Propoxyphene, Pentazocine and Meperidine were initially marketed as having low addictive potential. Physicians incur great faith in knowledge gained through their practice. Their ego is strengthened as they see their patients improve. Some physicians develop a god-like image of themselves — or their patients promote them to that position.

This is an unhealthy attitude which can result in self-treatment when symptoms develop. They observe patients obtaining relief from uncomfortable feelings through chemicals. When the physician feels stress such as tension cephalgia in a busy office practice, a short acting benzodiazepine can bring about relief to finish the day more comfortably. Increasing dose and

frequency may result as tolerance develops.

Most physicians have received little prior education in chemical dependency and do not recognize a problem when it develops. They are unaware when withdrawal symptoms present and they medicate inappropriately when they occur. Psychoactive drug use resulting in impairment in the physicians family structure and the professional work place will be rarely recognized by the self-prescribing physician. Unfortunately, physicians have no more immunity toward addictive disease than nonphysicians.

Through education, physicians are becoming more aware of adverse effects of psychoactive drug use in themselves and their colleagues. Physicians need to avoid self-treatment. When short term use of opiates or sedative drugs is necessary, a personal physician should be consulted and to manage medication needs. Curb-side consultation and concern regarding professional courtesy or impingement on a colleague's time will delay good medical treatment. This is not fair to either doctor. Just as a physician conscientiously desires to prescribe safely for his patient, the physician similarly deserves good medical care.

The Alabama Physicians Recovery Network (formerly Impaired Physicians Program) provides advocacy for physicians who may be impaired. Physicians concerned about themselves or their colleagues may contact The Alabama Impaired Physicians Program by a confidential call to 205-261-2044 or 1-800-239-MASA. Alabama law provides immunity for all referral sources.

## References

1 McAuliffe, William E., et al. Psychoactive Drug Use Among Practicing Physicians and Medical Students. *New England Journal of Medicine*. 1986; 315: 805-810

2 AMA Council on Scientific Affairs: Results and Implications of the AMA-APA Physician Mortality Project. *JAMA*, June 5, 1987 Vol. 257, No. 21

3 Personal Communication: Florida, Georgia, Mississippi Impaired Physician Programs



# A+

NEW INDICATION

## ONLY ONE H<sub>2</sub>-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H<sub>2</sub>-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150 mg b.i.d.**, relieves heartburn in **86%** of patients after one day and **93%** after one week.<sup>1</sup>

**AXID**<sup>®</sup>  
nizatidine  

---

150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

**AXID**<sup>®</sup>**nizatidine capsules**

**Brief Summary:** Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks. 2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.

**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

NZ-2347-B-249304

© 1991, ELI LILLY AND COMPANY

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by McQuick Print, formerly MASA Services. Communications should be addressed to *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-239-MASA.



# Newly Licensed Doctors

Cohen, Michael Victor, M.D.  
USAMC/Department Cardiology  
2451 Fillingim Street  
Mobile, AL 36617

Davidson, Robin Lee, M.D.  
928 Whiting Circle  
Department Anesthesiology  
Huntsville, AL 35801

Harmon, Harvey Scott, M.D.  
P. O. Box 13588  
Department Family Medicine  
RTP, NC 27709

Harmon, Renee Brown, M.D.  
P. O. Box 13588  
Department Family Medicine  
RTP, NC 27709

Phillips, Thomas William, M. D.  
Baptist Medical Center DeKalb  
Dept. Orthopaedic Surgery  
200 Medical Center Drive  
Ft. Payne, AL 35967

Sowell, John Kenneth, M.D.  
13111 West Markham, Unit 108  
Department Dermatology  
Little Rock, AR 72211

Stringer, Winfred H ., M.D.  
1400 University Boulevard  
Department Internal Medicine  
Mobile, AL 36609

Vaughan, William Perry, M.D.  
UAB / Hematology-Oncology  
UAB Station - THT 513 M  
Birmingham, AL 35294

Casarona, Charles Anthony, M.D.  
37 Medical Park  
Department Pediatrics  
Valley, AL 36854

Sechler, Joseph William, M.D.  
501 Eagle Ridge Drive  
Department Pediatrics  
Birmingham, AL 35242

Festok, Muhamad Mazen, M.D.  
Etowah Quality of Life Council  
P. O. Box 87  
Gadsden, AL 35902

Padilla, Jose S., M.D.  
P. O . Box 1293  
715 West Sherman Avenue  
Harrison, AR 72602

Routman, Alan Stuart, M.D.  
4101 NW 4th Street  
Dept. Orthopaedic Surgery  
Plantation, FL 33317

Drew, John Lyman, D.O.  
P.O. Box 30065  
Enterprise, AL 36330

Hunter, James Harold, M.D.  
1204 Wylde Green Road  
Iowa City, IA 52246  
After 6/30 /92  
USAMC/Dept. Internal Medicine  
2451 Fillingim Street  
Mobile, AL 36617

Sargent, Douglas Allan, M.D.  
377 Fisher Road, Suite G  
Department Psychiatry  
Grosse Point, MI 48230

Simmons, Donald Richard, M.D.  
Cunningham Pathology Associates, PC  
Midtown Center  
1801 1st Avenue South  
Birmingham, AL 35233

McBryde, Angus Murdoch, M.D.  
USAMC /Orthopaedic Surgery  
2451 Fillingim Street  
Mobile, AL 36617

Wahl, Joseph William, M.D.  
2717 Highland Avenue, Apt. 706  
Birmingham, AL 35205

Warren, Walter Richard, M.D.  
201 Park Street  
Bowling Green, KY 42101

# IS YOUR Coverage Just Window Dressing?



OPEN TIL 2

Things are not always what they seem. The coverage you buy is often not the coverage you think you are buying. It looks like a great deal; you save so much money, and the carrier seems so concerned and interested. . . until after you sign the check.

Don't let this happen to you. If you want a

company that offers vigorous defense, gives you final say in settling claims, and stands behind the coverage and defense you pay for. . . then check out ICA. We'll tell you the real story.

If you have *real* concerns about your malpractice coverage, then look into a *real* company with *real* people.



Insurance Corporation of America  
4295 San Felipe P.O. Box 56308  
Houston, Texas 77256-6308  
1-(800)-899-2356 (713) 871-8100

**Defending Defensible Doctors**



Sutherland, Timothy Bruce, M.D.  
American Sports Medicine Institute  
1127 12th Street South  
Birmingham, AL 35255

Brandt, Stephen Raymond, M.D.  
200-A Hospital Avenue  
Department Pediatrics  
Ozark, AL 36361

Bruce, Roger Dean, M.D.  
2660 10th Avenue South,  
Ste. 636  
Department Neonatology  
Birmingham AL 35205

Carter, Gregory Edward, M.D.  
2907 Hunter's Hideaway  
San Antonio, TX 78230

Friedberg, Richard Charles, M.D .  
618 South 18th Street  
Department Pathology  
Birmingham, AL 35233

Huggins, David Preston, M.D.  
Coastal Anesthesia  
P. O. Box 9754  
Mobile, AL 36691

Massingale, Harold Lynn, M.D.  
Humana Hospital - Shoals, Emerg. Dept.  
201 Avalon Avenue  
Muscle Shoals, AL 35661

Philip, Varkey E., M.D.  
56 Bay Bridge Drive  
Emergency Medicine  
Gulf Breeze, FL 32561

Runge, Paul E., M. D.  
6618 Monticello Lane  
Department Ophthalmology  
Memphis, TN 38115

Smith, Kevin Raynard, M.D.  
McCullough Plastic Surgery Center  
1600 Twentieth Street South  
Birmingham, AL 35205

Wells, Marcus Leon, M.D.  
7850 South Memorial Parkway

Department Internal Medicine  
Huntsville, AL 35802

Kaul, Bupesh, M.D.  
USAMC / Department Anesthesiology  
2451 Fillingim Street  
Mobile, AL 36617

Arnold, Thomas Lee, Jr., M .D.  
4160 Carmichael Road, Ste. 101  
Emergency Medicine  
Montgomery, AL 36106

Ofili, Elizabeth O., M.D.  
Etowah Quality of Life Council, Inc.  
P. O . Box 97  
Gadsden, AL 35902

McDonald, Jay McKay, M.D.  
UAB / Department Pathology  
UAB Station, West Pavilion, P220  
Birmingham, AL 35233

Evans, George Anthony, M.D.  
64 Ontario Street  
General/Family Practice  
Trenton, Ontario Canada K8V-6H9

Manyam, Kurmanath, M.D.  
125 Pinefidge Drive  
Anesthesiology  
Newark, NY 14513

Summer, Gerald L., M.D.  
Medical Association of the State of AL  
19 South Jackson Street  
Montgomery, AL 36104

Jones, Harvey Michael, M.D.  
UAB/Department Dermatology  
UAB Station  
Birmingham, AL 35294

Plavsic, Branko M., M.D.  
USAMC / Department Radiology  
2451 Fillingim Street  
Mobile, AL 36617

Hudson, Earnest, D.O.  
Family Practice Center  
7833 2nd Avenue South  
Birmingham, AL 35206

# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM**

**\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The **1991 National Defense Authorization Act** directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

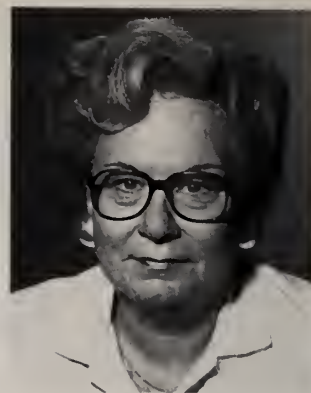
**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**





*Mrs. Stuart K. Bean  
A-MASA, President*

## Dr. & Mrs. James Kimble: Habitats for Humanity

By Donna K. Specker

On some Saturdays, when a lot of doctors are swinging golf clubs, Dr. and Mrs. James Kimble are swinging hammers. On these weekends they are helping build new, low cost homes for needy families by working with Habitats for Humanity.

The Kimbles join such notables as former President Jimmy Carter, actor Paul Newman, and singer Amy Grant as supporters of this international, ecumenical Christian organization which focuses not just on constructing houses, but also building homes and families.

Dr. and Mrs. Kimble have been involved with Habitats for Humanity since 1986 when Mrs. Kimble first heard about the program while in Montgomery, Ala. "I decided this was something that needed to be done," says Mrs. Kimble. "Then I made the mistake of offering my living room as a meeting place!" She soon became the founding president of the Montgomery chapter. Since moving to Birmingham, the Kimbles have continued to be active with Habitats, and both Dr. and Mrs. Kimble have served on the board of directors.

"Simple, decent housing is the goal of Habitats for Humanity," reports Mrs. Kimble. Houses are usually built wherever property has been donated, often in racially mixed neighborhoods. With lots of volunteer labor and donated materials and services, the standard-sized 1050-square-foot home that Habitats for

Humanity builds in Birmingham costs around \$30,000. It is individually designed by local architects who contribute their services and work closely with the new owners to create a house that meets their needs. "These houses are not just boxy copies of one another. They are designed to be individual," says Mrs. Kimble. "They are also made with good quality materials to be low-maintenance homes. Most, for example, will have vinyl siding and will never need painting."

A non-interest loan from Habitats for Humanity is arranged for qualifying households. No family is just given a home; they must buy it. According to Mrs. Kimble, the Birmingham Habitat sponsors 25-year mortgages and requires payment into an escrow account that reimburses for taxes and insurance, just like conventional loans.

One of the major differences, however, is something called "sweat equity." In lieu of a down payment, which many poor families do not have, new homeowners must put in 300 hours of work on their own homes and those of others. This "sweat equity" helps people respect the work that goes into building their home. They learn a few building skills. But best of all they realize that the volunteers, who may be doctors, lawyers, business owners or accountants, are people who care and can be trusted friends.

Another big difference is the requirement that all homeowners belong to a Family Nurture Organization. This self-help group learns budgeting,

hears local speakers, gets tips on repairing and maintaining a home, and generally finds out what it means to be a home owner. "This is very important for people who have always lived in a project," says Mrs. Kimble. They may never have had to make a repair or even arrange to have the utilities connected. One Habitat for Humanity chapter maintains a "tool pool" that includes a lawn mower, ladder, and more expensive tools for the members in the Family Nurture group to share.

But one of Habitats for Humanity's greatest achievements, says Mrs. Kimble, is that it helps people "develop not just houses, but also develop communities. This means not just the physical fact of owning a house. It means a diverse group of people with different beliefs and of different races working together."

Such interaction also builds families. Mrs. Kimble recalls that the first family which she worked with in Montgomery was a mother with six children whose 13-year-old son put in much of the sweat equity. Having a decent home apparently helped the whole family because the mother went on to earn a degree in medical office management. The son no longer felt ashamed to bring friends home, and his mother reported that he got into less trouble at school.

Choosing qualified families is a complicated process for the Habitat Selection Committees. According to Mrs. Kimble, people may be recommended for the program or ask for applications themselves. But the family must be truly needy. Sometimes the head of household makes too much money to qualify. If he or she could get a regular bank loan, the application is ruled out. Yet the family must earn enough to make a minimal monthly payment on their home. A stable family situation is a plus, and a family that has younger children at home may be favored over one with older children who may soon leave.

Habitats for Humanity is funded by donations from individuals, churches and organizations. For example, South Central Bell employees recently sponsored a Birmingham home. They provided money for materi-

als and worked building the house itself.

Obviously, though, such a project needs some expert advice. "In Montgomery a volunteer came to work and saw we were not well organized," relates Mrs. Kimble. "He was a city councilman, but he was also head of the local Home Builders Association!" Since then the Association has worked closely with Habitats to organize work crews and the buying of materials.

Because so much of the labor and materials may have been donated to build a Habitat home, it may be worth much more than its selling price on the day the owner moves in. For this reason many Habitat chapters reserve the option to buy back houses if the owners must sell them.

When asked what she does best in home building, Mrs. Kimble laughs and says, "I'm good at sweeping floors. I don't do drywall or the roof. One takes more expertise and the other takes more guts!" Dr. Kimble, she says, enjoys building. During the week he is an ophthalmologist specializing in the retina. But on the weekends he usually spends one Saturday a month working at Habitat home sites. Dr. and Mrs. Kimble's 14-year-old son also joins in and has been helping since he was nine.

There is plenty of work to be done. Since 1987 the Montgomery Habitat has built eight homes. The Birmingham chapter includes nine properties and six that are in the planning stage at Pratt City.

If you are interested in volunteering or contributing to Habitats for Humanity, check your local telephone book first. There are chapters throughout Alabama. Over 700 are found in the United States alone, besides groups in 36 countries including New Guinea and the Philippines. Birmingham also boasts campus chapters at Birmingham Southern University, Samford University, and University of Alabama at Birmingham. Some high schools also have chapters.

But if your community does not have a chapter, perhaps you, like Mrs. Kimble, can volunteer your living room!



# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

FPs and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA. Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

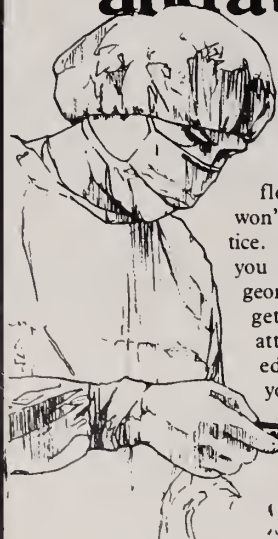
FP, IM, GP needed in rural South AL flourishing practice. Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

ER PHYSICIANS NEEDED for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

OPHTHALMOLOGIST WANTED for thriving, state-of-the-art eye practice in Columbus, Mississippi, seeking to add an associate leading to a partnership. Beautiful city of 25,000 with many varied recreational, social, and cultural activities. Competitive package. Contact Albert Laws, M.D. at (601)328-1254 or 2475 North 5th Street, Columbus, MS 39701.

Internist faculty positions open, University of Alabama School of Medicine, Huntsville Component. Rank from Assistant Professor to Professor, fulltime. Duties to include teaching junior and senior medical students and family practice housestaff; staffing Internal Medicine Outpatient Clinic; attending on the inpatient Internal Medicine Service. Salary commensurate with rank and experience. Respond to Internal Medicine Programs, UMC-201 Governors Drive, Huntsville, Alabama 35801. Equal Employment/Affirmative Action Employer.

## An Officer and a Surgeon



If you're a surgeon looking for a change of pace and a chance to sharpen your surgical skills, try your hand in the Air Force Reserve. Serve part-time. Our flexible participation schedule won't interfere with your private practice. Depending on your experience, you may qualify for the Flight Surgeon Program. As an officer, you'll get good pay, benefits and paid attendance to continuing medical education (CME) activities. Serve your country. Serve yourself. For more information, call (404)421-4892. Today's Air Force Reserve...it's a great way to serve.

**AIR FORCE RESERVE**

14-214-0004

**A GREAT WAY TO SERVE**

## SOUTHERN INDEPENDENCE

Large practice, small town. Established Family Medicine group in pre-revolutionary Pee Dee area community seeking physicians for a life-time commitment. New building, equipment, facilities, unequaled elsewhere. A truly special career opportunity in Family Medicine for a special physician. It don't get no better - friendly town with excellent quality of life. BC/BE only, please. \$100,000+. Want more info? Contact:

*Cheraw Family Medicine  
Attention: C. Radkin  
PO Box 867*

*Cheraw, South Carolina 29520  
(803) 537-2171. Call collect.*

# Equanimity

Lowell E. White, M.D.\*

Gordon E. Carroll, M.D.\*

Jack O. Yeager, M.D.\*

The provocative and scholarly nature of Dr. Lazenby's comments on "Commitment" prompts the three of us to comment further since we have been discussing for quite some time his premise that "Physicians may rightly wonder whether the devotion of their lives to the science and art (of Medicine) was not somehow a mistake."

We quite frankly believe, as he does, that it was not a mistake. Taking a brazen and philosophic approach, it can be said, "Two rights do not make a wrong," but it does not follow "TWO wrongs do not make a right." On occasion, the latter can be used as a measure of social progress, illustrated by Aristotle's support of Homer on the poetic approach to artistry in ethics, and the prose of Herodotus in the fictitious account of the ideals of the losers in the Poloponnesian War.

Simple syntactical examples of this strategy are Aesop (550 B.C.) *The Goose with the Golden Eggs*, "...he killed and opened it only to find — nothing...", and Shakespeare (1564-1616) *Julius Caesar*, "...I came to bury Caesar, not to praise him...."

It was in the area of social responsibility and its relation to health that Sir William Osler directed his lecture "Aequanimitas." He said, in summary, be imperturbable of body (avoid negative body language) and equanimitous of mind (always give your patient and family an even break), a point hammered home whenever one reviews contemporary works on this issue such as *"Searching for a Modern Hippocrates,"*<sup>1</sup> edited by Dr. Roger Bulger.

We three do not profess to have the answers, but we do feel in this day and age of accelerating communication, that asking the right questions is probably more important than the answers, because it is most

likely the answers that perturb us in the first place. Similarly, it is undoubtedly why Sir William used the metaphor, "Knowledge comes, but wisdom lingers."

During the period of the 90's or the Decade of the Brain, we as practitioners of medicine might take some solace in the wisdom behind the suggestion that the brain processes information by groups of cells or digital units. Therefore, the process cannot be approached in a purely reductionistic, and therefore, economic way. In sheer defence for a strong set of mind so important to the practitioner of medicine, surgery, or psychiatry, one takes further solace in Cicero's comments (106-143 B.C.) on a similar issue: "There is nothing so ridiculous but some philosopher has said it" (*De Divinatione*); "I would rather be wrong with Plato than right with such men as these (the Pythagoreans)" (*Tusculanae Disputationes*). Could it be that our society has evolved a system of socialized medicine based on the free enterprise system?

It is a matter of record that organized medicine, due to the collective nature of politics in North America, came out firmly against socialized medicine as envisioned by the economic insurance system, a system which looked upon the hospital as a potential public utility. That could have been all right if they had not wanted to throw the practitioner of medicine into the "pork barrel" with the rest of the health care team, a point the British government seems to be slowly revealing over three score years, mirrored by our colleagues in Canada.

Socialized medicine came to be in Scandinavian countries during the industrial revolution prior to the Twentieth Century, and health care is quite good there. The obvious Western World question is "Why?" Could it be that hospitals, as cultural public utilities for dying, have evolved through technological advances into health risk facilities? Is not the

---

\*University of South Alabama College of Medicine, 2451 Fillingim Street, Mobile, Alabama 36617.



practitioner, as well as the sick patient, still a guest in the hospice as well as the sick patient, and both at health risk?

The three of us think it is beneficial at this point to again review the World Health Organization's definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." As citizens, we would ask the question, "Is medical malpractice insurance health insurance?"

We would start our next thought with a question, because doctors as we know them today are no different than they have always been. The respect that the public has for their individual practitioner is quite high as confirmed by recent questionnaires reported at American Medical Association gatherings. Is the problem in this age of specialization the public distinction between the doctor as a learned man, and the learned man who becomes a practitioner of medicine? This question usually comes out of the public sector as, "Are you a real doctor?"

We must admit that today it is hard to answer this question, but information pertaining to the answer may be found in the educational process within our universities, for several changes have taken place since the Great Depression and World War II. Probably first and foremost is the tendency for University and College administrations to listen more to the students than to the faculty, a point eloquently discussed by Dr. Bloom in "The Closing of the American Mind."<sup>2</sup> With these changes, passing standardized examinations was removed from the responsibility of the student and placed squarely in the hands of the curriculum. Do these scores measure the quality of the curriculum?

No longer could the good teacher and practitioner approach pedagogy through his life-long hobby and pass his knowledge as a true scholar on to the students. "Publish or perish," being the buzz words of our time, has sincerely influenced the collegiality of the student body and faculty. The student on the other hand, although still coming into medical school with the usual high grade point averages, performed poorly in the essay and verbal response to educational dialogue, the buzz word for them becoming "objective examinations." Few medical students fail; the majority still withdraw of their own volition. However, one observation is disturbing to us; the students still come to medical school motivated as always with the priorities 1) altruism, 2) social status, and 3) income. This readily can be determined in the free university setting with a high degree of confi-

dence approaching the 95th percentile. Between the Junior and Senior years, these priorities change with the degree of confidence falling below the 85th percentile, and income replacing status as the second priority. This makes us wonder if the curriculum of today is more conducive to stamping out disease than to helping people?

Samuel Langhorne Clemens, under the pseudonym of Mark Twain, once commented: "I never let my schooling interfere with my education." Any ethical practitioner of medicine soon finds out what the public meant when they coined medicine as "A rich man's hobby." It is truly a hobby rich in life's values but not necessarily monetary as one reaps the praise and respect of a grateful patient. Further, it is easy to see the economic basis for the Robin Hood system, since there is nothing economic about health or motherhood. Have we relinquished our fiduciary responsibility (better known as "hand in the pocketbook") for our patients to a third party?

If so, as in Sir William Osler's time, 85% of the true destructive bodily diseases occur in only 25% of the population. Yet, 75% of the public is being asked to foot the escalating health care costs; the majority of this escalating cost has little or nothing to do with physicians' fees. We would hope the public, when sick, will continue to reward the physician graciously when we do our best to help them get well. Maybe the problem from a health risk point of view is defining who is sick and who is well?

It is perturbing. The three of us hope the public does not see anything in the majority of practitioners' behavior to confirm these questioning comments. In moving toward this country's form of socialized medicine, are medical faculties running scared, and further, are we practitioners relinquishing our individual fiduciary responsibility to our patients to some bureaucrat? Will another member of the health care team become the public's practitioner?

We hope the wisdom and education gleaned at the bedside will maintain your imperturbability and through this, organized medicine will bring an equanimitous social solution to the calamitous situation in which medical practice finds itself. All things considered, we would leave you with the Latin prescription: *Illegitimus non carborundum*.

## References

1. Bulger, Roger. *In Search of the Modern Hippocrates*. University of Iowa Press, Iowa City, Iowa, 1987.
2. Bloom, Allen D. *The Closing of the American Mind*. Simon and Schuster, New York, 1987.

**The AMA  
Hospital Medical Staff Section  
Nineteenth Assembly Meeting  
June 18-22, 1992  
Chicago Marriott Hotel  
Chicago, Illinois**

**Highlights of the Annual Meeting will include  
an educational program on:**

**Option 1: Medical Staff Bylaws: Principles and Practices**

Medical Staff leaders will receive a practical overview of the purpose, function and organization of medical staff bylaws, including discussion of selected provisions regarding the Health Care Quality Improvement Act, provision for policy statements, and other relevant issues. Participants will have the opportunity to participate in discussion, and ask questions pertinent to your own institution. Speakers will include legal experts from the American Medical Association and from private medical staff attorney firms.

**Option 2: Outcomes Management: A Medical Staff Issue**

Medical staffs are confronted with increasing pressures to respond to patient care data that is being collected for outcomes measure, quality assurance, utilization review and for other hospital purposes in the interest of quality and efficiency. Medical staff leaders will be provided with a perspective in data collection and outcomes management, and will hear how to focus data collection for successful and appropriate application in the interest of improved patient care. Speakers will be physician experts in the field of outcomes management and total quality improvement.

**For Information Contact:**

Department of Hospital Medical Staff Services  
American Medical Association  
515 North State Street  
Chicago, Illinois 60610  
Phone (312) 464-4754 or 464-4761



**HMSS**





The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia, HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

A91CA6148T

When diet and exercise alone are not enough...



ONCE DAILY 180mg Calan SR Verapamil HCl 180mg SUSTAINED-RELEASE CAPLETS

March 1992

Vol. 61, No. 9

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

THE FRANCIS A. COUNTRYWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

MAY 29 1992

FRANCIS A. COUNTRYWAY  
LIBRARY OF MEDICINE  
10 SHATTUCK STREET  
BOSTON, MA 02115-6011

**YOU  
ARE  
HERE**



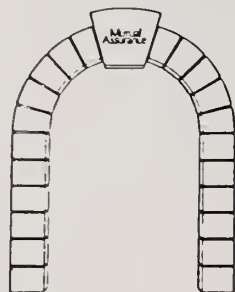


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 9, MARCH 1992

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1992 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Mills, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Jael C. Pittard, M.D. (1992), Opelika; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula; 1992 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Ellam McCrory, MD (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

## EXECUTIVE DIRECTOR

S. Lon Conner

Secretary-Treasurer - Emmett Wyatt

## DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

LIBRARY OF MEDICINE  
BOSTON, MA

MAY 29 1992

## In This Issue

<i>Addressing Alabama Advocacy For The Impaired Physician.....</i>	2
Gerald L. Summer, M.D.	
<i>Executive Director.....</i>	4
<i>'We Have Defrauded the Country'</i>	
<i>President's Page.....</i>	6
<i>Health Access America</i>	
<i>Under Pressure.....</i>	9
Tom McKell, M.D.	
<i>Life After Medicine.....</i>	12
Stanley D. Hand, M.D.	
<i>Fitness and Healthy Alabama 2000 Health Objectives.....</i>	19
Kennon Francis, PhD	
<i>Auxiliary.....</i>	28
<i>Dr. &amp; Mrs. Stuart Bean</i>	
<i>Classifieds.....</i>	30
<i>Newly Licensed Doctors.....</i>	31

## Cover:

This computer circuit board symbolizes the impact the computer revolution has had on the full sweep of medicine, from high technology imaging and other diagnostic and therapeutic tools to reimbursement; from medical review (whereby almost anyone can play doctor with the appropriate software) to practice guidelines and parameters. From the outset it was understood, if only dimly, that the computer's influence for good would be offset in some degree by its capacity for mischief and evil, the worst fear being that human beings and human conduct would be relegated to binary-code bytes. That fear remains.



# Addressing Alabama Advocacy For The Impaired Physician

*Gerald L. Summer, M.D.*

*Medical Director, MASA Physician Recovery Network (PRN)  
(Formerly, Impaired Physicians Program)*

The American Medical Association (1986) defined the impaired physician as one who is unable to practice medicine with reasonable skill and safety to patients because of mental illness, physical illness, or excess use or abuse of drugs, including alcohol.

Because the consideration of an impaired physician is complicated by preconceived ideas, carries social stigma, and is easy to hide, the exact incidence is unknown. The incidence of alcoholism is probably the same as the non-professional population. However, self-medication leading to controlled substances is shown to be higher in physicians.<sup>1</sup> Practitioners are falsely protected by an unconscious distortion of the facts. This denial results in changing practice styles to accommodate chemical use and for alcohol use.

Colleagues, family, and office personnel become enablers, and, through their own denial, protect the impaired physician. Physician - peer conflict, fear of liability or simply "not wanting to be involved," delay referral of possibly impaired physicians for needed evaluation. These actions prevent the impaired physicians from avoiding consequences of his or her illness. As a result, the illness frequently progresses, resulting in multiple complications including mental and physical illness, family disruption, disciplinary action by licensing boards and death.

The dilemma of the impaired physician did not go unnoticed by physicians in Alabama in past years. MASA physicians in 1978 began developing an impaired physician program. Antiquated Alabama reporting laws in the 1980s did not deter MASA volunteers from their endeavors to assist their colleagues.

The result was the Alabama law (88-536) in 1988 enabling the Alabama Board of Medical Examiners to contract with MASA for the creation of the Alabama Impaired Physicians Committee to promote early identification of physicians who may be impaired. This legislation provides several advantages for physicians.

Recognizing illness as an mitigating factor, the law provides a therapeutic alternative to the disciplinary progress. Physicians who have the disease of chemical dependency have the opportunity for adequate evaluation and treatment without fear of punitive action by regulatory boards. As long as the individual is compliant with the recommendations of the treatment provider, the Board need not become involved.

The legislation also provided therapeutic intervention and treatment concurrent with disciplinary action. In some cases, the illness may have progressed to impairment of professional performance, where patients safety is the primary concern. Temporary withdrawal from practice may be necessary until recovery has progressed to a point that patient safety is assured. The law provides the licensee an opportunity to re-enter practice after completing treatment and progressing in recovery. Most impaired physicians return to being productive individuals in the community.

Most importantly, incentive for early intervention and treatment is provided within the statute. Alabama law (34-24-36 and 34-24-360) provides immunity for concerned colleagues who, in good faith, make a report to the Alabama Physicians Recovery Network (PRN). This encourages detection of earlier impair-

ment. The reports are confidential and the referral source may not be revealed. Furthermore, all official records of the Alabama Impaired Physicians Committee (now PRN) are confidential and cannot be accessed. These records are maintained in the program's office located in the MASA Building in Montgomery. It follows then that physicians-peer conflict and fear of legal reprisal are no longer valid concerns. Genuine concern for assisting our sick colleague assumes its justified priority.

The Alabama Impaired Physicians Program (the Physicians Recovery Network, PRN) employed its first full time Medical Director on Oct. 1, 1991. The program offers Alabama physicians adequate time and expertise to evaluate confidential referral of physicians who may be involved with substance abuse or other illness which would tend to lead to impairment in professional performance. Referrals may be from concerned colleagues, hospital administration, nurses, family or other concerned individuals.

The reports are discretely evaluated, respecting the dignity and anonymity of the physician involved. If the available information indicates the need an intervention is done based on an honest, caring and understanding approach. No punitive impression is reflected in the meeting. If the intervention is consistent with the need, an evaluation by a committee-approved treatment provider is recommended. As long as the physician is compliant the regulatory board need not become involved.

Advocacy for the Alabama physician who may be becoming impaired can start by a call to the Physicians Recovery Network at 205/261-2044 or 1-800-239-MASA.

## References

1 McAuliffe, W.E., et al. Psychoactive drug use among practicing physicians and medical students. *New England Journal of Medicine*, 1986;3N:805-10.

# AIM HIGH



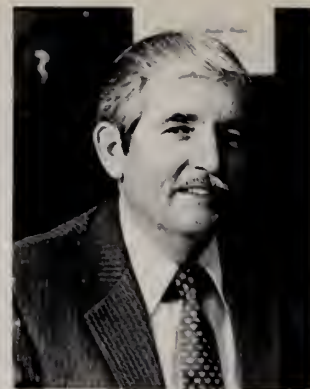
## FLIGHT SURGEONS WANTED.

Discover the thrill of flying, the end of paperwork and the enjoyment of a general practice as an Air Force flight surgeon. Take flight with today's Air Force and discover quality benefits, 30 days of vacation with pay each year and the support of a dedicated staff of professionals. Enjoy a true general practice on the ground, with the kind of stimulating challenge that will get your medical skills airborne. Talk to an Air Force medical program manager about becoming an Air Force flight surgeon. Call

**USAF HEALTH PROFESSIONS**  
**TOLL FREE**  
**1-800-423-USAF**







*S. Lon Conner  
Executive Director, MASA*

## 'We Have Defrauded the Country'

When New Hampshire Republican Warren B. Rudman announced in March that he was retiring from the U.S. Senate, Washington and the nation lost one of its few genuinely honest men. Warren Rudman never turned away from what he perceived to be the truth, unpopular though that might be with his colleagues in either party. He is that rarity of modern politics, a statesman.

At the time of his announcement, Senator Rudman was the fifth Senator to announce he was quitting. Subsequently, there were two more. The reason he gave for leaving was known to have been his feeling for many months — that the government of the United States is, as he said, "not functioning." He included the executive as well as the legislative branch in that assessment.

In the last year or two, particularly, partisanship and posturing had made service in the Senate ignoble, at least for him, he said:

"Here we are, getting zero done, staying up to midnight debating amendments that everyone knows won't become law, because somebody wants to get a press release out."

He expressed profound fear for the tragedy that awaits this country if it continues to refuse, as it has for so long, to face up to fiscal reality — that massive debt will ultimately drag down the vaunted American standard of living and that the United States will become a second or third rate economic power taking orders from its creditors.

He does not see this tragedy as far-fetched. Rather, he says, it is already happening, but few in

Washington, or in the nation for that matter, seem to care.

Just two weeks before his resignation announcement, he rose in the Senate to denounce, characteristically, both the Democratic tax bill and President Bush's proposal as frauds:

"There can be no doubt that sustained record budget deficits, high real interest rates, and the devotion of an increasing portion of the economy to pay interest on the skyrocketing national debt is the primary factor.

"And there can also be no doubt that the blame for this lies with the Congress and the President, with Democrats and Republicans alike, most of whom have been unwilling to make the hard choices or to explain to the American people that there is no such thing as a free lunch."

But even as he spoke, candidates for Congress and the presidency were promising just that. Coming from someone who has earned respect for his even-handed attack on both political parties, that should have had a major impact.

It did have one impact, at least. Three days later, Senator Danforth, Missouri Republican, spoke on the floor of the Senate in similar tones but went even further:

"... Why is that so many of our colleagues in the Senate are expressing unhappiness about serving here? I think there are a couple of reasons for it."

First, he said, but least important, criticism from press and public begin to gall after a while. But that, he said, was an insignificant cause of the discontent.

The major cause of the unhappiness he said, was guilt:

"... Deep down in our hearts we believe that we have been accomplices to doing something terrible and unforgivable to this wonderful country. Deep down in our hearts we know that we have bankrupted America and that we have given our children a legacy of bankruptcy.

"We have done even more than that. We have gone to people and said, you know the great issue is fairness; you have been treated unfairly; you, the American people, have been treated unfairly. You are asked to do too much. The burden is too heavy for you. We do not listen to you. If we listened to you, we would not treat you so unfairly.

"Do you know what is unfair? Your taxes are too high. Your benefits are too low. You are asked to shoulder too much of the burden. That is the basic message we have given to the American people. You should feel sorry for yourselves. You are Americans. Is that not pitiful? Your burden is too heavy."

Such egregious pandering, Senator Danforth continued, continues to mask the harsh truth:

"This is the first generation in the history of the country that has wanted to take more out of it than it is given. We can continue this. I do not have any doubt about it. We can continue this course. We can continue to do this. We can continue to, say, get us through the 1992 election. It is a presidential year, and what is more, Senator So-and-So is up for re-election this year. Get us through, no hard choices this year; then 1994, 1996. We can go on ... for the rest of the terms of everybody now serving in the Senate — at least one more time, because we have found some other group of people to hold the bag. Our children —

let them worry about it.

"The problem is that we have hurt America — quite intentionally, we have hurt America for the purposes of getting ourselves elected. We have told Americans that they should feel sorry for themselves. We have told them we can give them something for nothing. We have told them we can reduce taxes and we can increase benefits, and the numbers do not add up....

"It is a fraud. It is a fraud. We have defrauded the country to get ourselves elected...."

+++

If I could be Senator for a day, with one wish only to be granted, I would mandate that Senator Danforth's *mea culpa*, together with selected readings from Warren Rudman, be the compulsory preamble to every tax bill and appropriation bill and, most assuredly, every national health care bill introduced for the next generation.

The terrible thought, however, is that it may be too late to start telling the truth to the American people, even if a few in Washington felt so inclined. We have been lied to for so long, and lied to ourselves for so long, the brutal reality of this country's plight may simply be unbelievable. Or, worse, hopeless.

It was a liberal commentator, after all, who posed the question in somewhat this manner: What can be said of a people who will throw out a Congressman who bounced a \$400 overdraft in the House bank, which didn't cost taxpayers a penny, but hold no one accountable for a \$400 billion overdraft in the budget that will cost us and our children dearly?

After all, what is a mere \$400 billion, when the accumulated deficit, called the national debt, is headed toward \$4 *trillion*?





*William D. Lazenby, M.D.  
President, MASA*

## Health Access America

In June of last year, AMA officials met with the then White House Chief of Staff John Sununu to discuss health care reform. With AMA's Health Access America already being widely discussed in Congress and across the land, AMA Executive Vice President James S. Todd, M.D., wanted to sound out the Administration's views.

For his trouble, Dr. Todd was roundly excoriated by Sununu for even bringing up the subject. Sununu railed against the AMA for daring to even discuss health care reform with congressional Democrats and others. The Administration was in no hurry to present any kind of reform bill, or even to talk about one, Sununu said. He treated his AMA guests as if they were loonies.

Seven months later, in January of this year, Dr. Todd again met with the White House Chief of Staff. This time the reception was warm and sincere, reflecting the Administration's intense interest in health care reform. Two things accounted for the difference in the receptions between June and January: 1. Sununu had been replaced by Chief of Staff Samuel Skinner. 2. In November a prominent member of the Bush Administration, Dick Thornburgh, had been trounced in a Pennsylvania election for the U.S. Senate by the darkest of dark horses, an unknown academic whose election was perceived to have been attributable to one issue — health care reform. In the election, Thornburgh had taken the Bush Administration position at that time — that is, no position.

President Bush, who had hoped he could get through the 1992 election without a national health

care proposal, thus had his wake-up call — although the polls had shown the high intensity of public interest in health care reform, Bush had tried to ignore it until Thornburgh crashed in flames.

Thus by the January meeting between Dr. Todd and the new White House Chief of Staff, the President had undergone an election conversion. Years ago, AMA sensed the dynamics of the issue and acted. The result is Health Access America, which attempts to cobble together the private and public sectors to create a multi-layered universal health insurance plan.

It embraces the present insurance program that already serves more than 80% of the population. Employers who be mandated to continue such coverage or pay a special tax for that purpose. Hence the nickname for this feature of the AMA plan and some present Democratic proposals as well — play or pay. Health Access America would also expand Medicaid, to seal the cracks, and these and other mechanisms would, it is hoped, cover virtually all of the population.

In theory, this would put an end to the cost-shifting whereby payers of one class of beneficiaries attempts to buck his costs to the other guy. If everyone is covered, according to the theory, cost-shifting would become simply moot.

Health Access America should thus be a major theme, now, of all state societies because there are already forces at work to undercut such a plan. Most big employers and a growing number of smaller ones are now self-insured, which removes them from state insurance laws. Courts have held that they may do just about anything they desire to dilute their cover-

# ON INVESTING — TRUE OR FALSE?

## PART I

T F

- ☒ ☐ Bears make money. Bulls make money. Pigs get eaten.
- ☒ ☐ The historical, average net profit earned from investing in stocks in this country approximates 10% per annum.
- ☒ ☐ The usual effect on a portfolio from the actual loss of principal is more serious than the loss of potential profits.
- ☐ ☒ Risk is usually evident in any investment and is easily understood.
- ☐ ☒ Rates of return are usually calculated the same way by most financial professionals.
- ☐ ☒ Expenses paid by you (such as commissions, trustee's fees, etc.) to achieve returns should not be taken into account when calculating your rates of return on investments.
- ☒ ☐ Inconsistency in rates of return is more typical than not and is damaging to the growth of your assets.
- ☐ ☒ Selling too soon is a sure way to do poorly.
- ☒ ☐ Flexibility — and the ability to change investment positions quickly — if necessary — at a minimum of expense — if any — is essential to consistently achieving above average rates of return.



### INVESTMENT ADVISORY & MANAGEMENT CORPORATION

Suite 2110 First National Bank Building  
Mobile, Alabama 36602

1-800-239-1666  
In Mobile (432-1666)

Our stated objectives to every client are to:

- (1) Make our best efforts to consistently achieve at least a 10% per annum rate of return on all money entrusted to us — net of all expenses we are allowed to control — year after year after year.
- (2) Safeguard all money entrusted to us as principal. We endeavor to maintain principal in foundation type investments which generate funds for somewhat more aggressive investments.
- (3) Represent you — and no one else.

For further information as to what we do — and how we might be of assistance — please contact us.

Registered Investment Advisor

With the U.S. Securities Exchange Commission and The States of Alabama and Mississippi

This document is proprietary and confidential information of Investment Advisory & Management Corporation, Copyright applied for.



age of employees.

Even capricious and arbitrary cutbacks are permitted under the federal ERISA program, which contained a clause preempting all state laws on the subject. Some employers still offer their workers better benefit packages than would be required under state insurance laws, but others are rapidly diluting their policies and the trend is ominous.

AMA and others are asking Congress to close the ERISA loophole. A major assumption of Health Access America was that business and industry would continue their broad and deep coverage pretty much as they have been doing since World War II. Obviously, if the ground is shifted under the AMA model, it would lose some of its credibility. It is my personal opinion that we should support AMA in its efforts to pass the ERISA amendment.

All state societies, I believe, should join in this support as a necessary precondition to the passage of any health care reform package with the AMA-type components in place. No structure built on quicksand will stand very long.

The Mobile County Society has received an AMA grant to establish a Health Access America demonstration project; we will be watching that effort with keen interest. Nothing state and local societies might due for the balance of 1992 will be more important than in educating, first physicians then the public, on the virtues of the AMA model.

The railbirds in Washington say no major health care reform bill is likely this year, despite all the overtures, but these next few months may well be critical in determining what laws are passed in 1993. What happens this year in shaping public and congressional opinion will determine, to a large extent, what kind of bill emerges.

This, then, is a call to the colors. All doctors should study the proposals and take every opportunity, in patient encounters, in civic club speeches, at the club, anywhere and everywhere to pass the word. This is the way public opinion is formed — at the grassroots level, not from on high.

I cannot overemphasize the importance of this effort to the future of American medicine. Literally at stake is the finest health care system in the world. We must not fail our patients. We must not fail each other. Get behind Health Access America. It's later than you think.

# YOCON®

## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

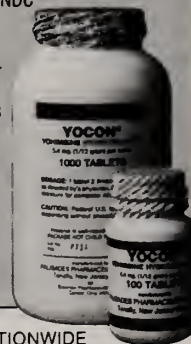
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES  
PHARMACEUTICALS, INC.**

219 County Road  
Tenafly, New Jersey 07670  
(201) 569-8502  
1-800-237-9083

# Under Pressure

## Soaring costs in health care will require some tough decisions

*Tom McKell, M.D.\**

*Reprinted from The Tampa (Florida) Tribune*

From the baby's first cry at birth to the last whispered breath at the close, we are all on the road to death. Our generation has been able to improve the physical quality of life on this journey and to delay that inevitable last moment, but we have failed to make adequate care within the reach of all. And part of the reason is that we spend too much money at inappropriate junctures in the health-care delivery system.

The cost for health care in this country is rapidly increasing, rising at least 10% a year and far exceeding the overall inflation rate. It dwarfs the savings and loan scandal, a one-time bailout, and exceeds the annual price for defense. It has become the Rogue Elephant of our economy.

Our outlay in 1990 was \$600 billion, and in 1991 it [was] predicted to be \$750 billion or, more graphically, \$3,000 per person. Even so, nearly 40 million Americans are either not insured or pitifully so, even though three-fourths of the adults in this group are working. In Florida alone, hospitalization costs jumped 16.6% [in 1990].

If health-care costs increase at the same rate they have in recent years, they will consume 25% of our gross national product by the year 2000 and approach \$2.5 trillion. This Rogue Elephant has not been corralled by any regulatory fences of government nor significantly controlled by private sector strategies such as health maintenance organizations, preferred provider organizations, or other managed health-care plans.

Has this great expenditure bought us a better state of health than the rest of the world? We spend a higher percentage of our gross national product on health care than any other Western nation. The result: On complicated cases, we can deliver the best care in the world, but overall, we do not accomplish this same level of quality.

Where does the responsibility lie for this failure? With doctors, hospitals, insurance companies, lawyers, or government? Or is the public responsible? The answer is, all of the above.

And the long-term solution will require cooperation among all of those groups.

There is no consensus on what needs to be done. The problem must be studied intensely and quickly to find one. But some answers already seem apparent. Billions of dollars could be saved just by taking these steps:

1. If the medical profession stopped ordering tests and doing procedures that have no demonstrable value, the nation could save as much as \$30 billion. Unfortunately, it's not rare for major surgery to be performed on patients for whom only a miracle, not medicine, can help. An enormous amount of Medicare money is spent on patients in the last few months of their lives, frequently in intensive care units where charges often approach \$2,000 per day.

2. If more Americans had well-composed Living Wills, another \$30 to \$40 billion might be saved by eliminating unwanted efforts to extend their lives when there is little chance of measurably improving its quality. Generally, we think of Living Wills as being important for elderly, but Karen Ann Quinlan and Nancy Kruzan were both young women. Fortunately, Congress has...passed legislation requiring all hospitals to discuss these matters with every new patient.

3. If we simplified the way we handle medical malpractice cases so that judgments were made more quickly, perhaps another \$1.5 billion could be saved. Now, an unconscionable amount of the settlement and court awards — more than 50% — goes to lawyers rather than to victims because the legal process takes so long. In more than half of the malpractice cases where a claim is paid, it takes more than three years before a settlement is reached. A well-designed arbitration system would relieve most of the legal costs even if no fewer claims occur and would result in awards being made sooner, thus being more beneficial to those who are damaged. It might also alleviate

---

*\*Dr. McKell has been a physician for 52 of his 76 years. He moved to Tampa in 1951 to set up practice with two friends and has been connected with Tampa General Hospital ever since, including a two-year stint as chief of staff. Since 1975, he has served as medical director at the huge public facility. He also is an associate dean at the University of South Florida medical school.*





**NEW INDICATION**

**ONLY ONE H<sub>2</sub>-ANTAGONIST HEALS REFLUX ESOPHAGITIS  
AT DUODENAL ULCER DOSAGE. ONLY ONE.**

Of all the H<sub>2</sub>-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.<sup>1</sup>

**AXID**<sup>®</sup>  
nizatidine  
150 mg b.i.d.

**ACID TESTED. PATIENT PROVEN.**

# AXID<sup>®</sup>

## nizatidine capsules

**Brief Summary.** Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. It overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP

[101591]

Additional information available to the profession on request.

**Eli Lilly and Company**  
Indianapolis, Indiana  
46285



pressure on doctors to order tests, studies and procedures solely to avoid malpractice suits rather than for sound, medical reasons. At least \$25 billion a year is wasted on defensive medicine.

4. Americans and their doctors must begin making tough decisions about whether tiny, premature babies with severe complications should be saved. Neonatology, the specialty dealing with these problem infants, is among the most costly components in U.S. health care these days. It is not rare to have these sickly children spend months, even years, in the hospital amassing bills approaching \$1 million apiece. An all-encompassing retrospective evaluation should be done to address survival at different birth weights and varying degrees of impairment and the costs involved as well as the effect on the integrity of families with these children. Several billion could easily be saved if we made more appropriate decisions in this area.

Physicians are not blameless for this waste of money. Too many have achieved enormous wealth from human suffering. We have not taken the lead in insisting that tests, procedures and treatment without proven merit be discontinued. We have not spent sufficient time educating our patients and their families as to what we and our technology cannot do.

We have not prepared ourselves and them for the inevitable cessation of life. We have not avoided the American tendency to become faddists in following the latest popular trend. We have not adequately coupled scientific dedication with compassion nor available interventions with the need to preserve a patient's dignity and quality of life.

But others besides doctors have responsibility for this mess, too. Our political leadership must stop ignoring the enormity of this health-care cost crisis and address their obligation to find a solution. The American people must also recognize that we can no longer afford to provide health care as we do today.

We do not have the luxury of time to solve this problem. Our resources are not unlimited. And for every dollar spent needlessly on health care, there is less to spend on education, transportation, defense, social services, adequate water supplies and environmental problems.

The solution when reached will be unlikely to satisfy any one of the groups or its individuals. It is past time for each of us individually and in the groups with which we are identified to promptly begin the search for answers in our own areas, to share these with the others, and to insist that our elected leaders organize and participate in such a forum.



# Life After Medicine

*Stanley D. Hand, M.D.\**

The late September weather in north Alabama had been hot and dry with temperatures high enough to set a number of new records, and, as we approached the Huntsville airport, Oct. 1, 1991, promised more of the game. The light jacket that I had on was not needed, but we knew that it would be much colder where we were going. When our plane landed in Jackson, Wyoming, the temperature was in the mid-thirties at night and only up into the mid-sixties during the day. We were met by a friend (a retired physician), his wife, and his young son, at the airport and we spent the night in Jackson with them.

Most of our first day in Wyoming was spent trying to get our hunting license cleared that we had applied for about two months in advance and had been lost by the Fish & Game Department. Early on the second morning we drove north through Yellowstone National Park, with a small log cabin in the foot hills of the Crazy Mountains of Montana as our destination. As we drove through the high mountain passes of Yellowstone we ran into the first snow storm of the year.

Our local friends called it a snow storm, but, when everything was completely covered with snow in about 30 minutes, it looked more like a blizzard to me.

That night, while sitting in front of a large roaring log fire visiting with our long time friend and his family, we did a lot of talking and reminiscing. He retired from medicine (dermatology) at the age of 49 because he could not stand the many changes that have taken place in medicine in the last few years. I could not help recalling the fact that he was only nine years old when I started practicing medicine in the small town

(pop. 6,000) of Athens, Alabama, only a few miles from where he was born and reared. After a long day of travel, loading and unloading cars and trucks, opening up the cabin and cleaning up around it, bringing in logs and starting fires, we were all tired. So everybody went to bed early and left me sitting alone on the floor in front of the big fire.

As I sat there looking into a bed of red hot coals, and watching the flames burn around the logs and the smoke and sparks disappear up the chimney, my mind drifted back over the many, many, wonderful experiences of a lifetime and the 41 years of family practice in a small town. I recalled a statement that I have often times repeated: "I have already had more fun in life than any one person deserves, so any fun or enjoyment from now on is just a bonus." As the fire burned down into a pile of glowing ashes, I recalled some of the highlights of my life and collected another bonus.

I, like most of you who have had the opportunity to be a doctor (a health care provider) and to be involved in the practice of medicine (the health care delivery system) when patients had a name instead of a number (health care recipients), would have to put that day when I walked across a stage in Memphis and received from the dean a diploma that made me a Doctor of Medicine as one of the highlights of my life. I was proud of the medical profession, proud of the doctors, and proud to be a part of it. Had my father lived to be there with me on that day I would have been even prouder.

All of the young men in my class had bought, or received in advance of graduation, a caduceus to be mounted on the tags of our automobiles. It was a symbol that told the world that we were Doctors of Medicine. We could then park in the doctors' parking lot at hospitals, get special parking at sporting events, and could sometimes get away with a little speeding. That caduceus was proudly moved from car to car over the next 30 years. But things changed over the

---

\*Doctor Hand has been a member of the Medical Association of the State of Alabama since 1948, and has been active in organized medicine since that time. He has served as a national delegate for the Alabama Academy of Family Physicians for twelve years, as a member of the board of directors for many years, and as its state president for one year. He has served on many committees for MASA, and has been a delegate and a counselor for over thirty years. He is now in retirement, teaching, lecturing, writing, fishing and hunting.

*Roche  
Laboratories  
presents the  
winners of  
the 1991*



Please join us in honoring these outstanding Roche sales representatives who have distinguished themselves by a truly exceptional level of professionalism, performance and dedication to quality health care.

Throughout the year, each of these award-winning individuals has consistently exemplified the Roche Commitment to Excellence, and we're proud to invite you to share in congratulating them on their achievement.



Hayes A. Salley



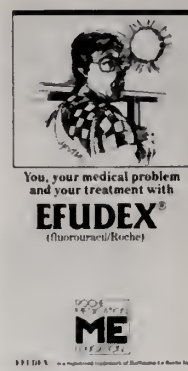
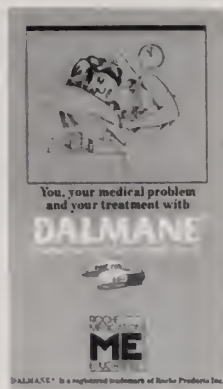
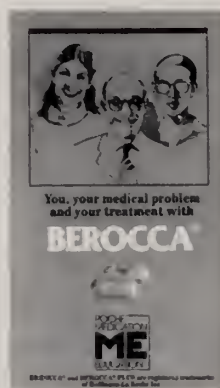
William Phillip Wiggins



# COMMITTED TO TOTAL HEALTH CARE

*Roche  
Laboratories  
presents the  
Resource Library  
for patient  
information*

ROCHE  
**ME**  
MEDICATION  
EDUCATION

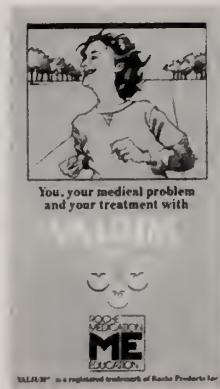
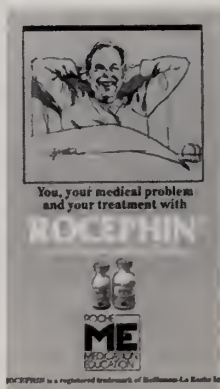
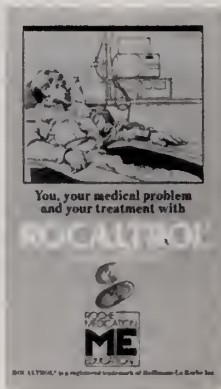
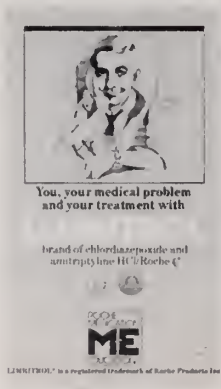
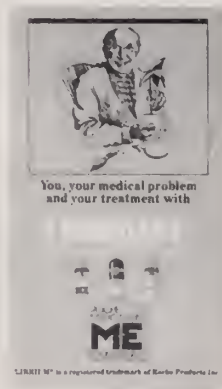


Your Roche representative offers you access – without expense or obligation – to a comprehensive library of patient information booklets designed to supplement rather than supplant your rapport with your patients.

Each booklet helps you provide...

- Reinforcement of your instructions
- Enhancement of compliance
- Satisfaction with office visits

Your Roche representative will be happy to provide a complete catalog of available booklets and complimentary supplies of those that are applicable to your practice.



last eight to ten years, and, when I bought a new car, that old caduceus did not get moved to the tag. Instead, it was thrown into the trunk and has long ago been lost.

Today while at the hospital I looked around the parking lot and saw only one caduceus on a car tag, and that caduceus was on the tag of a car driven by one of the emergency room physicians who goes to a number of different hospitals. What changed to make doctors of my time not as proud to display that old symbol? Why are so many doctor not as proud to be known as members of the medical profession?

At first the changes were gradual and did not change the doctor-patient relationship. The enactment by Congress in 1965 of Medicare-Medicaid under the Social Security Act, and its implementation in 1966, only changed what we were paid and the way we were paid for treating the old and poor people. Many, or most, doctors had been doing their fair share of work that we never got or expected to get paid for, and even though Medicare only paid 80% of our charges it was thought by most doctors to be better than nothing. But, as one would expect when the government got in on paying for medical care, the cost began to go up and up. The insurance companies, seeing an opportunity to make money, and the employers, trying to satisfy unions and labor, began to offer more and more medical coverage. During the 50s and 60s, before the day of Medicare-Medicaid and the insurance companies, almost every patient (90% +) paid the bill in full as they left my office.

Then came the late sixties and early seventies when these changes caused more and more patients to leave my office with the statement that they had insurance, Medicare, or Medicaid that would take care of their bills. Thus, a third party that was responsible for paying the bills had entered into the practice of medicine. The old adage, "He who pays the fiddler calls the tune," soon came into play. The government, soon followed by the insurance companies, wanted more say as to which patients should be admitted to the hospital, how long they should stay, what should be done to and for them in and out of the hospital, and how much the doctors should be paid for their services. Still, even with these changes, I loved medicine and my patients, looked forward to and enjoyed nearly every minute of my work, had pride in my work, my colleagues, and in the profession.

Then came the fourth and fifth parties into medicine; the lawyers and the government and insurance companies inspectors. By the mid-1980s things began to change so fast that it was impossible to keep

up with all of the changes. These changes came down as mandates, and I, for one, have difficulty knowing the difference between a mandate and a dictate. All through this time of rapid changes I continued to think that the doctors and the medical profession would tolerate only so much of this and then we will get together and resist, and then things would change for the better.

I thought to myself that the doctors are really smarter than the lawyers, and, when we were pushed far enough, we would get together and do something. I thought that eventually the doctors would tell insurance companies that the insurance contracts are between the insured and the insurer and that we, the doctors, were working for our patients and would look to them for our pay. At about this time I began to lose my pride in the medical profession.

My thoughts were interrupted by the flicker of flames at the ends of a nearly burned-out log, which brought me back to the small cabin in Montana. The room was beginning to feel cool, and, having turned out the lights earlier, the room was also getting dark. I got up, added two more small logs to the fire, sat down on the floor, leaned back on the couch, and watched the flames engulf the logs. With just enough light and warmth I drifted back into my thoughts.

Again my mind wandered back to the changes that have taken place in medicine and to those things that I had hoped and expected would take place but have not happened. The government and the insurance companies continue to pass more and more rules, regulations, restrictions, and issue more mandates for the doctors to follow. The year 1992 will bring a reduction in income to most doctors under the RBRVS act; you will not be allowed to send any Medicare or Medicaid patients to a laboratory in which you have any financial interest; you will pay the government a registration and inspection fee for labs, that you own or operate; you will have in-office inspections of records of all Medicare and Medicaid patients, and you will be told where you can invest your money that will not be a conflict of interest (safe harbors). Too, more than likely, you will in 1992 or '93 be forced to collect a "service tax" on all patients that you see.

The lawyers continue to make the doctors in court look like villains. They make it look as if all doctors are incompetent and stupid, and only interested in making money. I can't remember a case or fight with the government or the lawyers that the medical profession has truly won. Even when you win a malpractice case in court you lose some of your pride, your





**The cabin in the foothills of the Crazy Mountains In Montana where Dr. Hand sat in front of the fire ruminating on his life in medicine.**

self-esteem, your confidence in self and patients, your patients lose confidence in you, and you lose your time and income, and a lot of sleep. The lawyers, who never lose money, time, sleep, or self-confidence, are the only ones that consistently win in these medical suits. Some are saying that we have won in the case of RBRVS, but the government has won. They, the government bureaucracies, always ask for three times what they expect to get and consider a third to a half as a complete victory. No, we did not win that one or any others.

About two year ago I woke up one morning with the realization that I was no longer the boss in my office, that I had lost control of my practice, and, with it, I had lost my independence, and much of my pride in medicine. I was so dependent on, and enslaved by, the insurance companies and the governmental bureaucracies and lawyers that I could not continue to live with them, nor could I make a living without them. It was no longer the fun practicing medicine that it had been, and I was no longer as proud to be a doctor. I found myself even at social events not being very nice to people who complained about healthcare and its cost, and those who found doctor-bashing and healthcare-bashing to be a great sport.

I began for the first time thinking about quitting medicine, but the very thought scared me to death. I had far too many wonderful patients that I had been looking after for 30 to 40 years that I could not and would not leave without a doctor. Could I be happy or even live without being involved in medicine? Then came a young doctor to town looking for a practice and an office and some form of financing. The hospital agreed to the financing, and we agreed to work together for six months to see how things would work out. He is not only well-educated, smart, and relates

well to my patients, but he also has a good sense of values and a good outlook on life. After six months I knew that a few of my patients would not like him, but I felt sure that most would like him and get good care. I felt good about leaving my patients with him.

Not being financially as ready to retire as I would like to be, I decided to quit medicine (not retire) and do something else for a few years. Now I find that many doctors have preceded me, and I now predict that in the near future many more doctors will take early retirement, quit medicine or go into other fields. My dermatologist friend is now selling real estate in Wyoming and doing well. I met an early retired doctor at an art show last week that is now doing wood carvings and duck paintings and is making a living and having fun. I know a doctor who quit medicine and is doing volunteer work at a hospital; another that is selling insurance; and another who is working in a family business. If they can do it, why can't I?

What could I do that would be worthwhile, fun, make me enough money to pay for my hobbies, keep me occupied and out of trouble, and leave me some time to hunt, fish, and travel. About one month before I planned to quit work, the staff elected me Chief of Staff and changed the by-laws so I could hold that position and not be on the active staff. Also, the hospital hired me as a consultant at a small salary, and I am now finding more time for writing and have sold a few articles. I have more time for public speaking and am sometimes paid; and a lot more time for hunting and fishing. Had I known that retirement would be so much fun I might never have worked at all. Life after medicine can be meaningful, fun, and far less stressful.

Medicine was wonderful to me, and I am proud to have had even a small part in it. I would not have missed it for anything. I am still proud of most doctors that I think are the smartest, most dedicated, hard working, caring, fairest and most honest group of people in the world, but, it is hard to be proud of a constant loser and the doctors and the medical profession have been on the losing end for far too long. I wish that I could predict a change for the better in the near future, but I can't. We will see "Americare," National Health Insurance, or some other form of socialized medicine with a single payer system as soon as possible after the next national election. We will then have a healthcare delivery system with the compassion and consideration of the I.R.S., the efficiency and swiftness of the Post Office Dept., and with the expenditures and political pressures of the Defense Dept .



# FREEDOM FROM PAIN!

**Extra strength pain relief  
free of extra prescribing  
restrictions.**

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

## Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

## The heritage of VICODIN<sup>®</sup>\* over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin** **ES** 

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

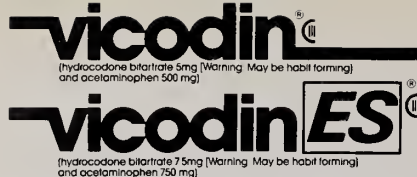
**Tablet for tablet, the most potent analgesic you can phone in.**

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit





**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

**WARNINGS:**

**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**PRECAUTIONS:**

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

**Use in Pregnancy:**

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/ VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Neonatal effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:**

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

**DRUG ABUSE AND DEPENDENCE:**

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/ VICODIN ES Tablets should be prescribed and administered with caution.

**OVERDOSAGE:**

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

In this time of "informed consent" and "signed consent" and "documentation," I can't help thinking of the days that are gone forever when my patients often said to me, "You are the doctor and you know best so do whatever you think is necessary and best for me." You better believe that with patients like that I did, to the best of my knowledge and ability, the best that I could do. Now a second opinion or consult is required for so many things. I sure would like to see doctors regain their freedom and their independence and quit working for hospitals, government, insurance companies, and the lawyers, and start working for and being paid by the patients again. Then I would be proud of the profession that I worked in for nearly 50 years.

The last flame flickered out in the fireplace, leaving only a pile of white ashes and a few glowing hot coals. The practice of medicine that I once knew and loved is, like that log fire, dying, and with it will go the good old country doctors. As I got up to go to bed I again thought that I am happy with my decision to get out of medicine. Life after medicine may not be as much fun, as meaningful, and as financially rewarding to all retired doctors as it has been to me, but, as for now, I can highly recommend it.



# Fitness and Healthy Alabama 2000

## Health Objectives

*Kennon Francis, PhD\**

### Introduction

We are in a time of great change with regard to our health status. Americans seem to have more interest today than ever before in the state of their health and how they can prevent disease. This concern is driven partially due to the exponential rise in health care cost and the desire to remain healthy and avoid costly hospitalization. Not only is the general public interested in a healthier America, but the government is also making a strong effort to improve the health of the nation. On Sept. 6, 1990 the U.S. Department of Health & Human Services released the report *Healthy People 2000*, the national public health goals and objectives for the 1990s<sup>1</sup>. This report is the result of an intense effort of cooperation among government, voluntary and professional organizations, business and individual citizens to significantly improve the health of Americans by the year 2000. The report includes 22 priority areas and 300 specific, measurable targets that address the leading causes of death and disability (Table 1). These objectives call for improvements in health status, risk reduction, public and professional awareness, health services and protective measures, as well as the mechanisms necessary for surveillance and evaluation of these objectives.

Most states, including Alabama, have already begun setting their own state health objectives for the year 2000, modeled on this national effort. In order to determine which specific objectives were more germane for Alabama, seven public hearings were conducted throughout Alabama during January-February 1991 to solicit comments, induce discussion and entreat responses as to how the health of Alabamians could be enhanced. Approximately 2,000 interested community members and health professionals attend-

ed these meetings and submitted oral and written testimony. The accumulated testimony was used as a guide for the selection of priority areas for Alabama's health objectives. In April 1991 a statewide conference, co-sponsored by over 60 organizations and attended by more than 700 individuals, met to further define and highlight needs and concerns of the public and various interest groups. Finally a task force was

**Table 1.**

#### **Year 2000 National Health Priority Areas**

##### **Health Promotion**

1. Physical Activity and Fitness
2. Nutrition
3. Tobacco
4. Alcohol and other drugs
5. Sexual Behavior
6. Violent and Abusive Behavior
7. Vitality and Functional Independence of the Elderly

##### **Health Protection**

8. Environmental Health
9. Occupational Safety and Health
10. Unintentional Injuries

##### **Preventative Services**

11. Maternal and Infant Health
12. Immunization and Infectious Diseases
13. Human Immunodeficiency Virus Infection
14. Sexually Transmitted Diseases
15. High Blood Cholesterol & High Blood Pressure
16. Cancer
17. Other Chronic Diseases
18. Oral Health
19. Mental and Behavioral Disorders

##### **System Improvement Priorities**

20. Health Education and Preventive Services
21. Surveillance and Data Systems

\*University of Alabama at Birmingham, Division of Physical Therapy, Room B41 SHRP Building, Birmingham, Alabama 35294, (205) 934-3566.





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association

## Healthy Alabama 2000 Health Priority Areas

Priority Area	Number of Objectives
1. Chronic Diseases	21
2. Communicable Diseases	12
3. Environmental Health, Injury Control, and Occupational Safety and Health	13
4. Maternal, Reproductive, and Child Health	14

**Table 2.**

formed and work groups met from May to August to refine and revise objectives. The results were published as Healthy Alabama 2000: Health Promotion & Disease Prevention Objectives for the Year 2000<sup>1</sup>. Healthy Alabama 2000 retained the organization around the 22 nationally identified priority areas and four broad health headings to facilitate activities in overlapping areas and to simplify communication of the objectives to the media and the public. The objectives for Alabama are organized and numbered as shown in Table 2.

Some of the national objectives were considered more urgent by Alabama and were targeted for more immediate action. For example, approximately 60% of the public hearing comments were directed at improving the health indices which relate to the category, "Health Promotion and Preventative Services." Leading the list among these objectives is the improvement of physical activity and fitness.

**Table 3.**

### Alabama Physical Activity Objective

Increase the proportion of Alabamians aged 13 and older who engage regularly, preferably daily, in light to moderate activity for at least 30 minutes a day as follows:

	Baseline	Year 2000 Goal
Adults aged 18 and over	8.4% (1989)	30%
Adolescents aged 13-19	34% (1990)	50%

(Alabama Baseline sources: Alabama Department of Public Health, Bureau of Health Promotion and Information; Alabama Department of Education, Division of Student Instructional Services)

## Fitness and the Year 2000 Objectives

Few Americans participate in regular physical activity despite the potential benefits. Less than 10% of the U.S. adult population exercise at the minimal level recommended (20 minutes or longer, 3 or more days a week at an intensity of 60% or greater of cardiorespiratory capacity) for enhancing physical fitness. More alarming is the fact that today less than 50% of the adult population exercises 3 or more days per week for 20 minutes or longer regardless of intensity. Since a sedentary life-style is the most prevalent and modifiable cardiac risk factor, and given the impact that exercise can have on disease progression, from a optimal health perspective, increasing physical activity seems to be the most advantageous modification that Americans can make in risk reduction and enhancing their overall health<sup>5,10,16,19</sup>.

Today cardiovascular disease remains one of the major causes of death in the United States as well as Alabama despite the efforts made in health promotion during the 1980s. Acute myocardial infarction occurs in approximately 1.5 million people each year, and one third of all cases are fatal. In a report from the Centers for Disease Control (CDC)<sup>5</sup>, sedentary life style was the most prevalent modifiable risk factor for coronary heart disease (58%) followed by cigarette smoking (25%), hypertension (17%) and diabetes (5%). The CDC reports that the relative risk of sedentary persons dying of coronary heart disease is approximately twice as likely as physically active persons<sup>5</sup>. Based on these probabilities and the fact



that almost 58% of Alabamians lead a sedentary lifestyle, it is estimated that 34% (2,897) of the 8,472 persons dying from coronary heart disease in Alabama in the single year 1987 was attributed to a sedentary lifestyle.

Although improvement in fitness may be only one component of cardiovascular disease prevention, increased physical activity has been shown to have beneficial effects on several other risk factors that have been targeted for action by the year 2000, including obesity, cigarette smoking, elevated blood cholesterol and hypertension. Because the reduction of the risk for cardiovascular disease can have such a potentially significant impact on the health of America, an improvement in cardiovascular risk factors through increased exercise is specified as a major objective in the health promotion priority area of the Healthy People 2000 <sup>11</sup> (Table 1) as well as Healthy Alabama 2000 <sup>1</sup>.

Because it was felt that all the national goals for improvement of physical activity could be achieved in Alabama, only one of the many goals was chosen. Increasing evidence suggest that light to moderate physical activity, below the level recommended for cardiorespiratory fitness, can have significant health benefits. Even relatively modest increases in activity are associated with measurable benefits in persons who have been inactive. In addition, individuals are more likely to comply with light-to-moderate exercise than more vigorous activities. Therefore, the physical fitness goal shown in Table 3 was selected for implementation in Alabama and is focused on simply reducing inactivity and increasing light to moderate activity.

### **Physicians and Alabama's Year 2000 Fitness Objectives**

Healthy Alabama 2000 objectives are not just "public health" goals but are also intended to be implemented in conjunction with clinical services. Therefore, primary care physicians, internists, family practitioners and pediatricians are uniquely positioned to help implement the Year 2000 objectives. For example, more than 400 million visits to primary care physicians are made annually <sup>14</sup>. Over 90% of adults see a primary care physician ever 5 years and over 75% visit annually <sup>13</sup>. Because most patients view physicians as respected sources for prevention as well as medicinal therapy <sup>17</sup> and that 85% of adults indicate that a physician's recommendation would encourage them to increase their exercise level <sup>9</sup>, one of the most effective means by which a physician can have an

impact on their patients' health behavior is through integrated exercise counseling in their regular patterns of patient care <sup>6,14</sup>.

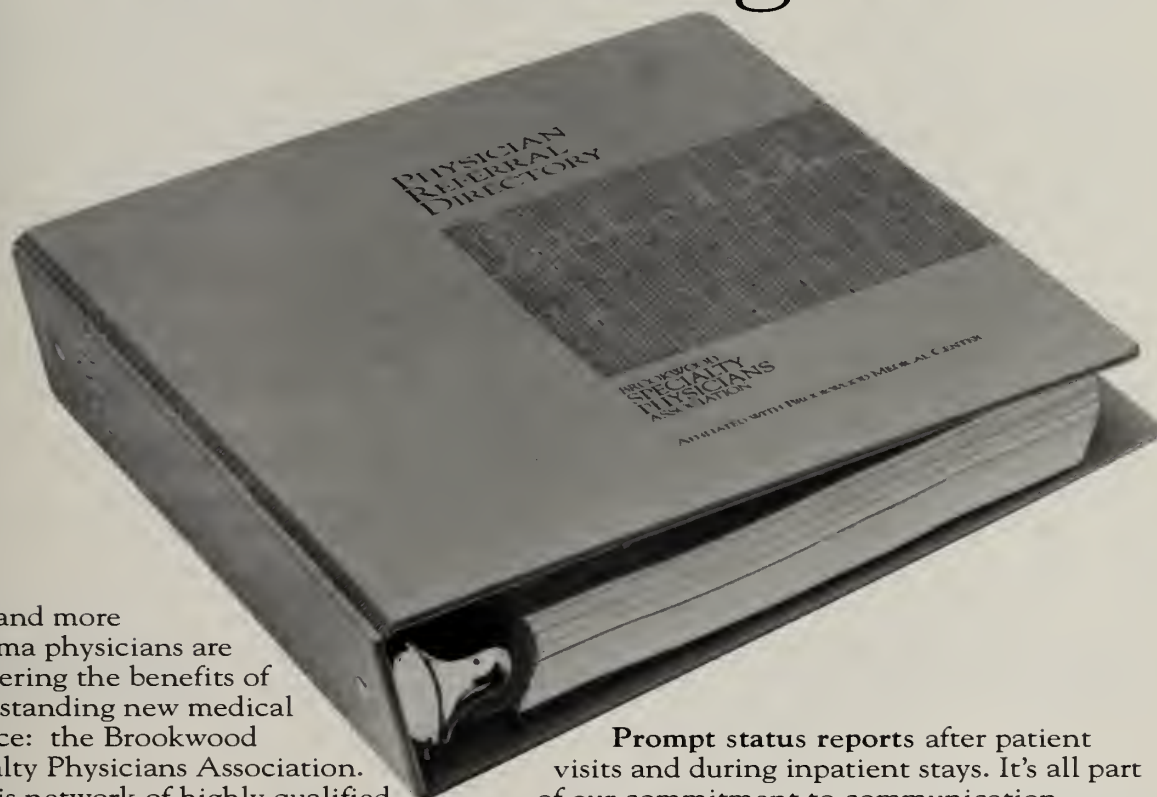
Physicians should take an active role in educating the public and providing realistic, practical information on the essentials of a properly formulated exercise prescription <sup>18</sup>. Physicians should be vigilant of the changes in the literature related to fitness as well as the various position statements and guidelines for exercise established by the national organizations concerned with health promotion through exercise<sup>3,15,19</sup>.

Physicians should strive to read the most current literature and understand the reasons and philosophies that energizes these guidelines. There are a number of excellent resource books summarizing much of the science behind the formulation of exercise guidelines<sup>2,16</sup>. The American College of Sports Medicine (ACSM) periodically publishes a helpful little book titled *Guidelines for Exercise and Testing* <sup>4</sup> that sets forth standards for exercise for individuals who desire to be certified by as exercise specialist by the ACSM. This is a rich source of specific guidelines for exercise that can be used by all health professional for designing exercise programs regardless of whether they choose to be certified by ACSM. In addition there are a number of recent, well written review articles related to health promotion, physical fitness and exercise prescription that provide additional information that can be used by the physician <sup>7,8,10,18</sup>. The American Academy of Pediatrics recently published a public education brochure entitled "Better Health Through Fitness." This brochure is targeted at children and adolescents and explains why fitness is important, defines the components of fitness and encourages young people to do some type of vigorous activity at least 3-4 times a week for at least 20-30 minutes.

Physicians should be aware of various exercise fads, fraudulent and unscientific methods, techniques and equipment that are advertised. Exercise equipment often is used by individuals who may not be familiar with its side effects or the proper way of using it. Physicians should educate and guide their patients as to the scientific merits, possible side effects and dangers of using these techniques and/or devices. For example, aerobic stepping is sweeping the country. Because stepping down is an eccentric motion, it is probable that the untrained individual will experience delayed muscle soreness 24-48 hours following their initial exercise sessions.

Physicians are also needed outside of the office

# Presenting The Medical Resource That More Alabama Doctors Are Referring To.



More and more Alabama physicians are discovering the benefits of an outstanding new medical resource: the Brookwood Specialty Physicians Association.

This network of highly qualified physicians represents virtually every medical specialty. But it's more than a group of doctors. It's a total system of convenient, comprehensive referral services:

**Physician Referral Directory**, a free, user-friendly guide to all our specialists.

**Toll-free referral line** for setting up referrals and making appointments.

**Prompt status reports** after patient visits and during inpatient stays. It's all part of our commitment to communication—ensuring that you, the referring physician, are an integral, informed part of the “care loop.”

For more information, or for your free Physician Referral Directory, call 1-800-292-4859 (877-1887 in Birmingham).

And see for yourself why more Alabama doctors are referring to the physician network that wrote the book on referral services.

BROOKWOOD  
SPECIALTY  
PHYSICIANS  
ASSOCIATION

AFFILIATED WITH BROOKWOOD MEDICAL CENTER

THE PHYSICIAN NETWORK THAT SPECIALIZES  
IN CONVENIENT, COMPREHENSIVE REFERRAL SERVICES.



environment to be role models as well as to provide health promotion and disease prevention lectures to community, business groups and local civic organizations<sup>6</sup>. Recently the Southeastern Regional Chapter of the ACSM instituted a speakers bureau to help provide speakers on physical activity and fitness to local community groups to help inform and promote the goals of Healthy People 2000. This is an excellent channel for physicians to participate in, to provide their expertise in health promotion. Additional information on local area representatives can be obtained from the author.

## Conclusion

The usefulness of health promotion philosophy and fitness activities for all individuals is apparent therefore challenges set forth in Healthy Alabama 2000 are before us. The establishment of measurable health objectives holds promise for enhancing health gains; however, setting objectives is, in effect, only a starting point. Attaining the Year 2000 objectives will require some major changes in our lifestyles and in the structure and function of our health care system. A concerted national, state and local as well as an individual commitment is required with new initiatives, dissolving of previous barriers, intensified and realigned efforts. Achievement of the goals will require a collective action among state government, business, labor, education and health professionals. Only with the sharing of talents and resources will the goals be met by the year 2000, resulting in a healthier state and nation.

## References

- 1) Alabama Department of Public Health. Healthy Alabama 2000: Health Promotion & Disease Prevention Objectives for the Year 2000 . October 1991
- 2) American College of Sports Medicine. Resource Manual for Guidelines for Exercise Testing and Prescription. 1988. S. Blair, P. Painter, R. Tate, K. Smith, C. Taylor, editors. Lea & Febiger, Philadelphia PA.
- 3) American College of Sports Medicine position stand. The recommended quantity and quality of exercise for developing and maintaining cardiorespiratory and muscular fitness in healthy adults. 1990. *Med Sci Sports Exerc* 22:265-274.
- 4) American College of Sports Medicine. Guidelines for Exercise Testing and Prescription. 4th Edition. Lea & Febiger, Philadelphia PA, 1989.
- 5) Centers for Disease Control. Coronary Heart Disease Attributable to Sedentary Lifestyle-Selected States, 1988. 1990. *JAMA* 261:1390-1392.
- 6) Cooper, D. Year 2000 objectives for the nation. The physician's role. 1991. *Clin In Sports Med* 10:223-226.
- 7) Cox, M. 1991. Exercise training programs and cardiorespiratory adaptation. *Clin Sports Med* 10:19-32.
- 8) Franklin, B., Bonzheim, K., Wetherbee, S., Gordon, S., and Timmis, G. Exercise and Fitness. 1990. *Obstet Gynecol Clin North Am* 17:817-835.
- 9) Harris L and Associates. Inc: The preventive index '89: Summary Report. Emmaus Pa. Rodale Press. 1989
- 10) Hartley, L. H. The role of exercise in the primary and secondary prevention of atherosclerotic coronary artery disease. in *Exercise and the Heart*, edition 2. N. K Wenger and A. N. Brest. editors. 1985. F. A. Davis Company, Philadelphia
- 11) Healthy People 2000: National Health Promotion and disease prevention objectives. 1990. Washington, D.C. Government Printing Office , DHHS publication no. (PHS) 90-50212.
- 12) Johns, M., Hovell, M. Ganiats, T. Peddecord, K. and Agras, W. 1987. Primary care and health promotion: a model for preventive medicine. *Am J Prev Med* 3:346-357.
- 13) Kligman, E., Kamerow, D., and Artz, L. 1990. Year 2000 health objectives and the family physician. *Am Fam Phys* 42:851 - 854.
- 14) Physical exercise - an important factor for health. A position statement from the International Federation of Sports Medicine (FIMS). 1989. *Int J Sports Med* 10:460-461.
- 15) Pollock M., Wilmore J. Exercise in Health and Disease. Evaluation and Prescription for Prevention and Rehabilitation. 2nd Edition, 1990. W.B. Saunders, Philadelphia, PA.
- 16) Promoting Health/ Preventing Disease: objectives for the Nation. Washington, D.C. US Department of Health and Human Services, Public Health Service, 1980.
- 17) Robert Wood Johnson Foundation: Updated report on access to health care for the American People. Weisfeld, V. Editor, Princeton NJ, 1983
- 18) Smith, C.W. 1989. Exercise: A practical guide for helping the patient achieve a healthy lifestyle. *J Am Board Fam Pract* 2:238246.
- 19) Statement on exercise. A position statement for health professionals by the Committee on Exercise and Cardiac Rehabilitation of the Council on Clinical Cardiology. American Heart Association. 1990. *Circulation* 81:396-398.

# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM**

## **\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**



# Call for Papers

## 1993 International Conference on Physician Health January 28-31, 1993. Scottsdale, Arizona

### *Facing Issues, Seeking Solutions, Advocating Help*

The 1993 International Conference on Physician Health, co-sponsored by the American Medical Association, the Federation of State Medical Boards, the Canadian Medical Association, and the Federation of Medical Licensing Authorities of Canada is scheduled for January 28-31, 1993, at the Marriott Mountain Shadows Resort in Scottsdale, Arizona. The conference will provide a forum for practitioners and researchers to present recent findings and innovative treatment and educational programs in the area of physician health. This conference will address a range of issues relative to physicians, including AIDS, the HIV positive physician, problems related to aging, health promotion among physicians, mental illness, physical disability, and substance abuse among physicians. Possible topics for presentation include: incidence of health problems among physicians, the presentation of health problems by physicians, their treatment, the impact of disorders on physician's family and practice, medical-legal implications of various disorders, and the impact of these disorders on hospital administrations. *Abstracts which address issues related to these topics (i.e., diagnosis, treatment, rehabilitation), but not dealing specifically with physicians are also welcome.*

Three types of presentations regarding these physician health issues are invited:

- **Poster Presentations**

Written presentations of data-based research, epidemiological research, or descriptive papers regarding treatment and educational programs.

- **Paper Sessions**

Oral presentation of scientific, data-based findings relative to topic of physician health.

- **Workshops**

Training or instructional presentations, designed to improve specific skill levels of persons who work in the area of physician health.

*Abstracts for poster presentations and paper sessions* should contain an introductory statement on the significance of subject matter. Description of methods, results, and conclusions should follow the introductory statement.

*Abstracts for workshops* should contain information on the program's intended audience, goals, teaching strategies, and materials. Evaluation data should be summarized.

Abstract may not exceed 200 words. Any abstracts exceeding that length will be rejected. Abstracts should be typed, double spaced, and mailed (not faxed). Four copies of the abstract should be sent, along with one self-addressed, stamped envelope. All submissions must list the primary and secondary authors and their professional affiliations. Telephone number and address of primary author must also be included.

Paper and Workshop submissions should indicate any audiovisual equipment that is needed.

### **Submissions *must* be received by June 15, 1992.**

Abstracts will be submitted for blind review. Abstracts will be judged on their applicability to the conference topic area and their scientific merit. The decisions of the blind reviewers will be communicated to the abstract's primary author by August 15, 1992.

All persons who have an abstract accepted for presentation at the conference are expected to register for the conference. We are unable to reduce registration fee for presenters, nor are we able to provide any financial support for presenters. All persons who attend the conference will be responsible for their own transportation and hotel expenses, as well as making all reservations for same.

*Send all materials to:*

Patrick W. McGuffin, PhD, Department of Mental Health, American Medical Association, 515 North State Street, Chicago, IL 60610.

## American Medical Association

Physicians dedicated to the health of America





*you mean this is what I've been training for all my life?*



He trains year-round on the weights and on the track. But it wasn't long ago when he thought the race was over.

A diving injury had left Sammy Shute a quadriplegic. That's tragic news for anyone, but especially someone like Sammy who's been an athlete all his life.

With a whole new set of issues to come to grips with in his life,

Sammy found the strength he needed in the therapy at MMRC.

"I looked at therapy as competition," he said. "To do something better than I'd done it before. I guess you could say I was in competition with myself."

Over time, the staff helped him realize that by giving 110 percent every day, there was a multitude of things a person could do in a wheelchair. Like racing, for example. He went on to become

an inspiration not only to others, but to the very people who'd been such an inspiration to him.

It's that one-on-one relationship between patients and staff that makes MMRC the South's leading rehabilitation center. If you don't believe it, come out to the races one day. You'll see the proud results from start to finish.



**MMRC**  
MISSISSIPPI METHODIST  
REHABILITATION CENTER

1350 East Woodrow Wilson, Jackson, MS 39216  
(601) 981-2611 or 1-800-223-6672





*Mrs. Stuart K. Bean  
A-MASA, President*

## Dr. & Mrs. Stuart Bean

**By Donna K. Specker**

Some people seem to fit more time into their 24 hours a day than others. Dr. Stuart Bean and his wife Jessie are two such people.

Dr. Bean is an emergency room physician based in Birmingham who is not only the medical director of BREMSS (Birmingham Region Emergency Medical Service System) but also a founding member of the federally sponsored Disaster Medical Assistance Team (D-MAT).

The D-MAT team was organized about two and a half years ago by the Public Health Service to coordinate efforts between military and civilian medical personnel in cases of national emergency.

According to Dr. Bean, who was one of the original team leaders, the purpose of D-Mat is to provide emergency triage for civilian catastrophes in which the local medical community is overwhelmed or perhaps destroyed. The team consists of five or six doctors, nurses, emergency medical technicians, ambulance drivers and others who are asked on short notice to fly to a disaster scene. Two years ago a team from Albuquerque, New Mexico, flew to aid victims of Hurricane Hugo in St. Croix, Virgin Islands. They joined the 109th Evacuation Hospital team, a national guard unit based in Birmingham, to provide emergency care in an area where the hurricane had devastated local medical service. Teams were also on standby when a major earthquake struck San Francisco in 1991.

There are about 15 D-MAT teams around the United States that are trained and ready to fly in a C-130 transport jet to the scene of an emergency. Several other teams are planned. Their specialty,

according to Dr. Bean, is air evacuation. Once they arrive, these teams can supervise triage and stabilization of the injured and send them to hospitals in other cities or states.

In a drill last year the Birmingham D-MAT team pretended a major earthquake had destroyed much of Memphis. The simulation included evaluation of moulaged victims who were to be sent to hospitals in other cities for longer term care. Military planes were scheduled to assist in the drill, but for this particular drill were not available. They had been called away for action in Operation Desert Storm.

Nancy Carlisle of BREMSS is also involved with D-MAT and recalls the team's training exercise in Biloxi, Mississippi, two years ago where the Birmingham team drilled with a gulf coast team. "Dr. Bean really enjoyed it," she says. "For him it was like a camp-out where he was camp leader." She recalls they trained on a stretcher obstacle course and learned how to transport injured over rough terrain.

D-MAT teams have been used at times when short term medical assistance was needed. The Birmingham team was present at the "June Jam" in Fort Payne, Alabama, last year, where they treated over 2000 patients as part of the medical staff on call for the event. This June the team has been called on to provide medical support at the Boston, Massachusetts, Sesquicentennial Celebration. Between 3 and 4 million people are expected for the "Tall Ships" celebration that is being planned, and such a sudden influx of humanity presents a strain on local medical services in the same way as a disaster.

The D-MAT project fits well with Dr. Bean's other interest as medical director of BREMSS. He acts as a



Dr. & Mrs. Stuart Bean

liaison with other doctors to promote the best utilization of emergency service personnel. This includes coordinating paramedics, ambulance personnel and pre-hospital care in emergency rooms for the six county area of Jefferson, Shelby, Chilton, Walker, Blount and St. Clair counties. He is also a representative on the State Medical Control & Accountability Committee, where he advises on medical policy for pre-hospital care.

Of course, Dr. Bean is not the only busy member of his family. Mrs. Bean is the current state president of the Auxiliary to the Medical Association of the State of Alabama (A-MASA). She is in charge of projects supporting medical families and specific health concerns as well as encouraging local auxiliaries to recognize their medical communities on Doctor's Day and contribute to AMA-ERF. This is a demanding job that requires hours and days of coordinating and delegating. But Mrs. Bean is accustomed to this after having also served as president of the Jefferson County Medical Auxiliary. She is also incoming president of the Women's Committee of the Alabama Symphony, president of the Birmingham district of the Kidney Foundation, and a member of the auxiliary of the Salvation Army. She has also volunteered for the next surgical mission undertaken by Operation Smile (See January *Alabama Medicine*).

Mrs. Bean's theme for her year as A-MASA president has been "First we gave you our heart; now we give you our support." She has often emphasized how valuable the spouse of a physician can be; the team of Dr. & Mrs. Bean is an excellent example of such synergy — put them together and you get years of service to the medical community.

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by McQuick Print, formerly MASA Services. Communications should be addressed to *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-239-MASA.



# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

Internist faculty positions open, University of Alabama School of Medicine, Huntsville Component. Rank from Assistant Professor to Professor, fulltime. Duties to include teaching junior and senior medical students and family practice housestaff; staffing Internal Medicine Outpatient Clinic; attending on the inpatient Internal Medicine Service. Salary commensurate with rank and experience. Respond to Internal Medicine Programs, UMC-201 Governors Drive, Huntsville, Alabama 35801. Equal Employment/Affirmative Action Employer.

FP, IM, GP needed in rural South AL flourishing practice. Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

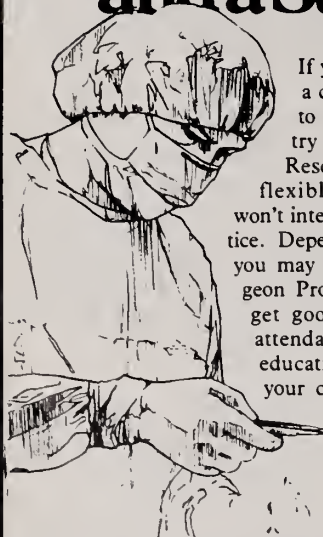
**Tired Of Night Call And Administrative Burdens? MISSISSIPPI.** An incredible practice is now available within a progressive, established group of Family and Industrial Medicine Physicians. No hospital call. **OWNERSHIP OPPORTUNITIES** in this expanding Episodic Care and Industrial Medicine Clinic system. Potential income of \$150,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Have a busy practice from day one, with extremely high, long-term income potential. Please send your CV to P.O. Box 13849, Jackson, Mississippi 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

**Tired Of Working For Someone Else With No Chance For Ownership? MISSISSIPPI.** Excellent opportunities for career-oriented Emergency Physicians. **OWNERSHIP OPPORTUNITIES.** Local physician owned and managed group with contracts in North, Central, and Southcentral Mississippi with potential income of \$200,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Positions available now. Please send your CV to P.O. Box 13849, Jackson, MS 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

**FPs and IMs DESPERATELY NEEDED IN BIRMINGHAM, MONTGOMERY, AND TUSCALOOSA.** Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**ER PHYSICIANS NEEDED** for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

## An Officer and a Surgeon



If you're a surgeon looking for a change of pace and a chance to sharpen your surgical skills, try your hand in the Air Force Reserve. Serve part-time. Our flexible participation schedule won't interfere with your private practice. Depending on your experience, you may qualify for the Flight Surgeon Program. As an officer, you'll get good pay, benefits and paid attendance to continuing medical education (CME) activities. Serve your country. Serve yourself. For more information, call (404) 421-4892. Today's Air Force Reserve...it's a great way to serve.

### AIR FORCE RESERVE

14-214-0004

A GREAT WAY TO SERVE

## SOUTHERN INDEPENDENCE

Large practice, small town. Established Family Medicine group in pre-revolutionary Pee Dee area community seeking physicians for a life-time commitment. New building, equipment, facilities, unequaled elsewhere. A truly special career opportunity in Family Medicine for a special physician. It don't get no better - friendly town with excellent quality of life. BC/BE only, please. \$100,000+. Want more info? Contact:

*Cheraw Family Medicine  
Attention: C. Radkin  
PO Box 867*

*Cheraw, South Carolina 29520  
(803) 537-2171. Call collect.*

# Newly Licensed Doctors

Miller, Samuel Jones, III, M.D.  
303 Medical Drive  
Department Ob-Gyn  
LaGrange, GA 30240

Guzman-Stein, Gabriela, M.D.  
UAB/Division Plastic Surgery  
UAB Station, MEB 524  
Birmingham, AL 35294

McLeod, Jeffrey Lance, M.D.  
Humana Hospital  
C/O John Robertson  
400 North Edwards Street  
Enterprise, AL

Carter, Lee Carson, M.D.  
Anesthesia Services of Birmingham, PC  
P.O. Box 530590  
Birmingham, AL 35253

Porter, Charles Edward, M.D.  
200 Colonial Homes Drive, #1109  
Atlanta, GA 30309

Gilbert, Rodney Bradley, M.D.  
629 Brent Street  
Winston-Salem, NC 27103

Holmes, James Pope, M.D.  
Crestwood Professional Building  
250 Chateau Drive  
Huntsville, AL 35801

Presti, Charles D., M.D.  
8333 North Davis Highway  
Department Internal Medicine  
Pensacola, FL 32514

Al-Hakim, Hasan B., M.D.  
2005 Treecrossings Place  
Birmingham, AL 35244

Angott, Allison Ann, M.D.  
Air University Regional Hospital/SGHF  
Maxwell AFB, AL 36112

Bachman, Adella Hill, M.D.  
UAB/Division Plastic Surgery  
UAB Station  
Birmingham, AL 35294

Beckett, William Wells, Jr., M.D.  
Radiology Associates of Dothan  
1900 Fairview Avenue  
Dothan, AL 36301

Bell, Joseph Taylor, II, M.D.  
Lester Clinic/Family Practice-Ob/Gyn  
P. O. Drawer A  
Lester, AL 35647

Bodurka, Diane Catherine, M.D.  
UAB/Department Ob-Gyn  
UAB Station  
Birmingham, AL 35294

Bowen, Johnny Lee, M.D.  
2600 Tambridge Circle  
Department Pathology  
Pensacola, FL 32503

Browning, James Louis, M.D.  
USAMC/Dept. Anesthesiology  
2451 Fillingim Street  
Mobile, AL 36617

Campbell, Patricia Lynn, M.D.  
360 Craigs Creek  
Department Family Practice  
Versailles, KY 40383

Crimmins, Lawrence Eugene, M.D.  
3929 Armour Avenue, #C-19  
Columbus, GA 31903-5369

Dilullo, John Angelo, M.D.  
3226 West Main Street, Suite 102  
Dothan, AL 36301

Gibson, Floyd Brian, M.D.  
420 Lowell Drive, SE, Suite 300  
Department Facial Plastic Surgery  
Huntsville, AL 35801

Gray, Joyce Lorraine, M.D.  
UAB/Department Pathology  
Div Lab. Med.  
618 South 18th Street, WP P230  
Birmingham, AL 35233

Hanrahan, Philip Anthony, M.D.  
2600 Vaughn Lakes Boulevard, #612  
Internal/Emergency Medicine  
Montgomery, AL 36117

Kendall, Mark Alan, M.D.  
UAB/Division Orthopaedics/MEB 502  
1813 6th Avenue South  
Birmingham, AL 35294

Mock, Robert Bradley, M.D.  
1125 Calm Water Court  
Department Anesthesiology  
Mt. Pleasant, SC 29464

Obiako, Chamberlain Iheyinchukwu, M.D.  
Etowah Quality of Life Council, Inc.  
P.O. Box 97  
Gadsden, AL 35902

Piccolo, Wesley Vincent, Jr., M.D.  
8133 SW 47th Road  
Department Anesthesiology  
Gainesville, FL 32608

Pinkard, Nanette Ballard, M.D.  
UAB/Dept. Pathology, Kracke Bldg.  
619 South 19th Street  
Birmingham, AL 35233

Reich, Debra Sue, M.D.  
UAB/Division Otolaryngology  
1501 5th Avenue South  
Birmingham, AL 35233

Renz, John Thomas, M.D.  
Radiologists, PC  
2504 Dauphin Street, Suite C  
Mobile, AL 36606

Rouse, Dwight Jonathan, M.D.  
UAB/Department Ob-Gyn  
UAB Station  
Birmingham, AL 35294

Satterwhite, Yvonne Edith, M.D.  
3921 Prytania Street, Apt. 2  
Department Orthopaedic Surgery  
New Orleans, LA 70115

Scalfano, Frank Paul, M.D.  
6823 Kitty Hawk Circle  
Department Diagnostic Radiology  
Pensacola, FL 32506

Shortall, Michael Anthony, M.D.  
Bibb Medical Center-C/O Terry Smith  
164 Pierson Avenue



Department Internal Medicine  
Centreville, AL 35042

Snoddy, Robert O'Neil, M.D.  
4550 Labrador Drive  
Department Family Practice  
Columbus, GA 31909

Trevisani, Mary Gina, M.D.  
52081/2 Hawthorne Place  
Department Ophthalmology  
New Orleans, LA 70124

Wenstrom, Katharine Dell, M.D.  
UAB/Department Ob-Gyn  
Division Maternal Fetal Medicine  
Birmingham, AL 35294

Teixido, Michael Thomas, M.D.  
1528 North 26th Street  
Department Otolaryngology  
Birmingham, AL 35234

Cowart, Steven Lanham, M.D.  
UAB School of Primary Medicine  
201 Governors Drive, Suite 103  
Huntsville, AL 35801

Fisher, Scott R., M.D.  
Coastal Anesthesia, P.C.  
P.O. Box 9754  
Mobile, AL 36691

Teasley, Denise Jones, M.D.  
USAMC/Department Ob-Gyn  
2451 Fillingim Street  
Mobile, AL 36617

Williams, Michael Brian, M.D.  
Internal Medicine Associates, PC  
121 North 20th Street  
Opelika, AL 36801

Ifediora, Okechukwu Chigozie, M.D.  
Renal-Hypertension Clinic, P.C.  
1404 East Main Street  
Dothan, AL 36301

#### LIMITED LICENSES

Greenhalgh, Christopher Andrew, M. D.  
USAMC/Department Anesthesiology  
2451 Fillingim Street  
Mobile, AL 36695

Desai, Pankaj M., M.D.  
P. O. Box 62/ UAB Station  
Birmingham, AL 35294

Morehead, Martha Shawn, M.D.  
7833 2nd Avenue South  
Department Family Practice  
Birmingham, AL 35206

Lue, Cummins, M.D.  
UAB/Medicine Housestaff Office  
UAB Station - 229 THT  
Birmingham, AL 35294

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

**P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992**

Above rates are provided by Jackson National Life

# The Alabama Physicians Recovery Network (PRN)

***(Formerly Impaired Physicians Program)***

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ◆ *Intervention*
- ◆ *Education*
- ◆ *Guidence to hospital, staff and employees*
- ◆ *Recovery monitoring*
- ◆ *Structured support groups*
- ◆ *Family assistance*
- ◆ *Advocacy*
- ◆ *Liason*
- ◆ *Quality Assurance*
- ◆ *Confidentiality*

***For information call: 1-800-239-MASA or 205-263-6441***  
***On weekends, after office hours and holidays call:***  
***1-205-271-5759***





The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

A91CA6148T

When diet and exercise alone are not enough...



ONCE DAILY 180mg Calan SR Verapamil HCl 180mg SUSTAINED-RELEASE CAPLETS

A MILD START IN MILD HYPERTENSION

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

## MELTDOWN

With U.S. health expenditures doubling in less than five years, with demand overwhelming resources, JAMA Editor George D. Lundberg, M.D. posits a worst-case scenario: a panicked Congress, circa 1996, nationalizes the health care system and conscripts physicians by that “meltdown” year unless — American medicine assumes strong leadership NOW.

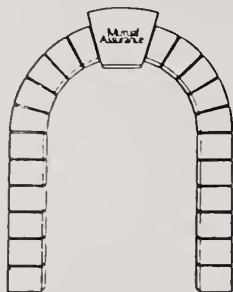


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 10, APRIL 1992

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1992 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Mills, Montgomery

OFFICERS OF THE ASSOCIATION: President - William D. Lazenby, M.D. (1992)\*\*; Opelika; President-Elect Peter W. Morris, M.D. (1992)\*\*; Birmingham; Immediate Past President - T. Riley Lumpkin, M.D. (1992)\*\*; Tuscaloosa; Vice-President - Joel C. Pittard, M.D. (1992), Opelika; Speaker, House of Delegates - Riebard O. Russell, Jr., M.D. (1994)\*\*\*; Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*; Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1991 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1992 Delegates - Julius Michelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1991 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - W. Earle Riley, M.D., Fairfield; Edgar W. Branyon, Jr., M.D., Anniston.

THE STATE BOARD OF CENSORS: James E. West, M.D., Chairman (1992), 3rd District, Anniston; Richard H. Esham, M.D., Vice-Chairman (1994)\*, Mobile; W. Earle Riley, M.D. (1992)\*, Fairfield; Eliann McCrory, M.D. (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; William C. Waller, M.D. (1992)\*, Montgomery; William M. Lightfoot, M.D. (1994), 1st District, Mobile; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Polmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

### EXECUTIVE DIRECTOR

S. Lon Conner

Secretary-Treasurer - Emmett Wyatt

### DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

Executive Director.....2  
*The Great National Whodunit*

President's Page.....6  
*Our Great Heritage*

*'The Tort System Is The Problem'* .....10  
Howard C. Snider, M.D.

*National Health Care Reform*.....15  
George D. Lundberg, M.D.

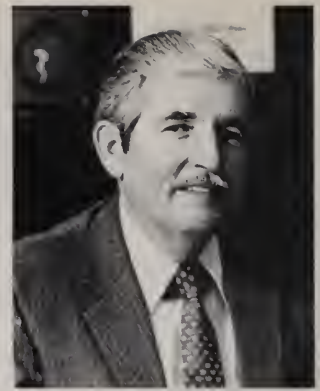
Newly Licensed Doctors.....24

*A Procedure To Assist Impaired Colleagues*.....31  
Gerald L. Summer, M.D.

Auxiliary.....32  
*The Image of Doctors in the 1990s*

Classifieds.....33





S. Lon Conner  
Executive Director, MASA

## The Great National Whodunit

In my last column I noted the tragic irony of the American public's outrage over a congressman bouncing a \$400 check off the House Bank, which costs taxpayers nothing, and that same public's seeming indifference to the current budget deficit of \$400 billion, or the total national debt now within striking distance of \$4 trillion.

As disgusting as the first is, it's a misdemeanor; the second a high felony bordering on treason.

Part of the problem is that we can identify with a \$400 overdraft because we understand such numbers. But it does little good to understand that \$400 billion is four hundred thousand millions, because most of us can't grasp millions either. And to entertain the thought that \$4 trillion is four thousand-thousand million is downright comical.

Even people whose second language is mathematics admit to having problems with the infinitely large and the infinitesimally small. One such is James L. Adams, professor in the Department of Values, Technology, Science & Society at Stanford. At one end of the scale, he writes, there are computer people who baffle him talking of nanoseconds and picoseconds (billionths and trillionths of a second). At the other are the glib economists and their trillions.

In his book, *Flying Buttresses, Entropy and O-Rings*, Professor Adams explains how science is engineered into products, how end-use problems are solved on everything from MRI to spacecraft. An engineer himself, he nevertheless confesses that the very large and the very small blow his mind until he finds a way to visualize such quantities.

"As an example," he writes, "I cannot think about the national debt until I reduce the numbers to some-

thing I am familiar with." The process by which he did this for himself serves to illustrate the point I have tried to make in several columns:

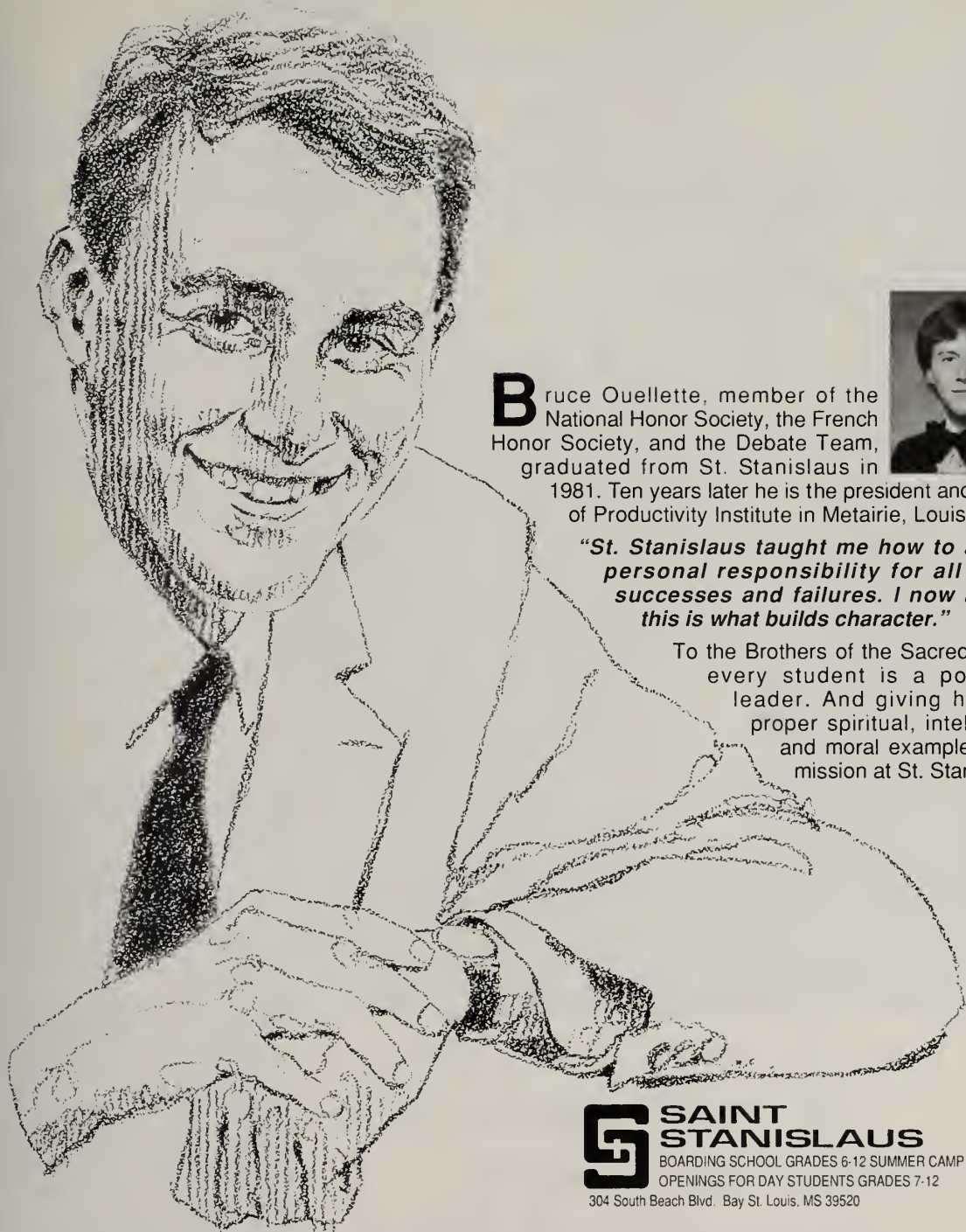
"A national debt of over \$2 trillion escapes me. [His book, published last year, seems to be based on debt figures from the good old days of 1989-90.] Now I happen to know for some reason that a piece of typing paper is about .003 inches thick, so a dollar bill must be about the same. Using arithmetic, I figure that \$2.5 trillion would make a stack of bills about 7 billion inches tall.

"This is about 100,000 miles or 12 times the diameter of the earth (which I happen to know is about 8,000 miles). So \$2.5 trillion is equal to 12 stacks of dollar bills, each equal to the diameter of the earth, which is something I can at least think about.

"Since there are approximately 250 million people in the United States, each person's share of the national debt is about \$10,000. However, 250 million is also difficult to think about. The Stanford football stadium holds about 80,000 people. I have seen it full, so I know how many people that is. If only 80,000 people assumed the national debt, each would owe about \$30,000,000, a bit steep even for Stanford alumni...."

Soon, when the debt reaches \$4 trillion, each of Professor Adams' football fans will owe 60% more (the increase from \$2.5 trillion to \$4 trillion) or \$48,000,000 each. They'd better start paying up before the tab gets out of hand.

We Americans rail against Congress and the presidency for relatively inconsequential matters but stand mute in the face of an outrageous ongoing disaster. We simply ignore things we don't try to comprehend. And the monstrous, suicidal debt has apparently no



**B**ruce Ouellette, member of the National Honor Society, the French Honor Society, and the Debate Team, graduated from St. Stanislaus in 1981. Ten years later he is the president and owner of Productivity Institute in Metairie, Louisiana.

*"St. Stanislaus taught me how to accept personal responsibility for all of my successes and failures. I now realize this is what builds character."*

To the Brothers of the Sacred Heart, every student is a potential leader. And giving him the proper spiritual, intellectual and moral example is our mission at St. Stanislaus.



**SAINT  
STANISLAUS**

BOARDING SCHOOL GRADES 6-12 SUMMER CAMP AGES 9-14  
OPENINGS FOR DAY STUDENTS GRADES 7-12

304 South Beach Blvd. Bay St. Louis, MS 39520

---

FOR A FREE BROCHURE CALL THE DIRECTOR OF ADMISSIONS — (601) 467-9057

---

# St. Stanislaus helps build leaders.

---



effect at all on our expectations from government.

Our want list grows in indirect proportion to our ability to pay. We want, and think we are entitled to, free health care. The operative word is "free." Let the government pay for it, millions of Americans say. And what is the government? Why it's those rascals up there who float hot checks and run up the national debt.

Most Americans, tragically, cannot see the connection between what they want and what it costs. And our chosen leaders, to their everlasting shame, feed this idiocy by promising more and more at no cost whatever to the recipients.

A corollary to this national insanity is the term-limitation fad. Now, the Founders of this Republic were pretty savvy people. They wanted to be able, for all time, to throw the rascals out too. So they bradded it into the Constitution that members of Congress must face the voters periodically to renew their employment.

But, we Americans say, our own congressman is not the problem: he gets things for us. The problem is everybody else's congressmen. We feel we should be able to stop them from re-electing those bums because they're throwing our money away on their constituents.

This mental process gives the game away: anything that benefits me is only social justice; anything all those others get is pork-barrel politics.

With such irrational attitudes constantly stroked by pandering politicians, is it even conceivable that this country could construct a sane and solvent universal health care plan?

But just for the sake of argument, however, let's assume that such a plan were enacted, one sound as a dollar used to be. How long would it take for Washington to utterly cripple it with overload?

Where did all this begin? Some say it began when the Reaganauts introduced the Laffer Curve, which purported to show that the more you slashed taxes the more revenue gushed into the federal coffers. Some say Lord John Maynard Keynes' influence on Roosevelt's New Deal started us down the road to ruin. Some blame everything on Dr. Spock.

Some say we went broke, as the the Soviets did, on national defense. Some say welfare bled us white. Some blame Social Security; some blame the poor, others blame the rich; some blame Democrats, others blame Republicans; almost everybody blames the Japanese.

We could continue this bootless search for scapegoats until the end of our civilization. The simple, unvarnished truth is that we are all to blame: both parties, the Congress, the Presidency, but most of all the people, who wanted it all and didn't want to pay for any of it.

# Emergency Medicine Opportunity



## *Phenix City, Alabama*

Located in Southeast Alabama across the river from Columbus, Georgia. Annual ED volume of 13,500 in this 300-bed hospital.

**SPECTRUM<sup>®</sup>**  
**EMERGENCY CARE**

A member of The ARA Group

P.O. Box 419052, St. Louis, MO 63141


## *The Spectrum Advantages*

- Very competitive fees.
- High-limit occurrence-based malpractice insurance.
- Flexible schedules.

For details call  
**Joyce Solomon or**  
**Carmine Iannotti at**  
**1-800-325-3982**



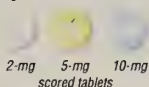
**Your Rx for  
Valium**  
(brand of diazepam/Roche)



**may be open to  
seventeen  
interpretations...**

**unless you settle the issue by signing  
on the "Dispense as Written" line.**

**VALIUM<sup>®</sup>**  
brand of  
**diazepam/Roche<sup>®</sup>**



*The final choice should really be yours*

The cut out "V" design is a registered trademark of Roche Products Inc.  
Copyright © 1991 by Roche Products Inc. All rights reserved.

**Roche** **Roche Products**  
Roche Products Inc.  
Manati, Puerto Rico 00701

\*According to the Orange Book, 10th ed, US Department of Health  
and Human Services, 1990, diazepam tablets may be available from as many  
as 17 companies. Tablets shown represent 5 mg diazepam tablets.





William D. Lazenby, M.D.  
President, MASA

## Our Great Heritage

*This is the last column of William D. Lazenby, M.D., as 1991-92 President of MASA. The following was given as his President's Report on the State of The Association to the College of Counsellors and House of Delegates, Orange Beach, April 1992.*

More than one hundred Alabama physicians have preceded me in the office of President of the Association. God willing, hundreds will follow me.

This unbroken continuum is emblematic of our profession: just as the preceding generations of physicians passed down to us the rich legacy of their campaigns against disease, public indifference and political resistance, so shall we add our small contributions to the ever greater heritage of medicine.

Every doctor now alive shares in the bountiful inheritance of medical history and progress; and each owes a corresponding duty to the generations to come of patients and their doctors. It is this bonding with the past and with the future that physicians should feel stronger than those in any other mortal calling, excepting only the clergy.

One way or another, the history of medicine, with its sweep and grandeur, recruited all of us. One way or another, it will recruit all those who are to follow us. It is thus our solemn obligation in these perilous times to preserve our patrimony from ages past, which we hold only in trust, enlarge on it, and pass it on.

---

Shortly after I took office last spring, HCFA enraged American physicians by publishing in the *Federal Register* proposed regulations that would have crippled the inauguration of the Resource Based

Relative Value System after years of work and the active cooperation of organized medicine. Our greatest fear from the outset was that government would somehow contrive to use only the proposed reimbursement reductions implicit in the plan, while omitting the increases.

Although the executive branch had assured and reassured the AMA that everyone was acting in good faith, that the redistributions would be "budget neutral," and Congress itself ordered such even-handed accounting, there were those among us who doubted the government's word. Sad to say, we had been deceived before.

When HCFA's proposed regs were published, it was clear that these misgivings had been justified. The uproar that followed the egregious attempt to slash the conversion factor by 16% was directed less at the actual cut than the duplicity of our own government. The indignant message from organized medicine was plain: if such a perfidious double-cross were allowed to stand, how could Washington ever expect to engage the profession again in negotiated solutions to national problems?

We had the overwhelming support of members of both parties in both houses of Congress, since they had been defied by the bureaucracy as well as we. In the Administration's backtracking that followed, we recovered most of what had been surreptitiously taken away, but far more importantly we had established our resolve to go to the mat with any administration to defend good-faith agreements.

Had we not done so, the whole country would have

been the loser because never again could there be such cooperation between the profession and Washington—once burned, twice shy.

I mention this episode because it reveals not only what we can do when we work together but it also reveals what I perceive to be the new look of the AMA in its Washington presence—willing to discuss problems and work sincerely toward their resolution but ever prepared to retaliate when we are sold down the river.

This is the face Dr. Todd has presented to the country—reasonable in all that can be negotiated but tough when crossed. He is walking quietly but this case illustrates he does indeed carry a big stick. I salute him.

Here in Alabama MASA's posture is similar, and nowhere is that better illustrated than in our protracted argument with the Department of Industrial Relations and its attempt to use the workers' compensation issue as an entering wedge to control medical practice in Alabama.

While we made many overtures to work with business and industry, we let it be known up-front that physician control of patient care was not negotiable

and never will be. We have stonewalled only that. Other matters were always on the table.

We support generally the concept of universal health insurance for everyone as embodied in the AMA model, Health Access America. This was carefully constructed after years of study and discussion and figures to be a essential concept for Congress to consider when it finally deals with the issue. No major legislation of this kind is expected this year, however, because of the national elections.

Your Board of Censors has labored long and hard through the year on literally scores of issues that concern, to one degree or another, attempts to invade or dilute the rights and responsibilities of medical practice, a struggle that has been with us since the earliest territorial government and will likely continue, such being the nature of man.

During the year, I used the President's page in *Alabama Medicine* in a way that Teddy Roosevelt once defined the national presidency—as "a bully pulpit." If I appeared to sermonize too much, attribute that weakness to many years of reflecting on my belief that physicians need to constantly rededicate

**AIM  
HIGH**



## CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

**USAF HEALTH PROFESSIONS  
TOLL FREE  
1-800-423-USAF**



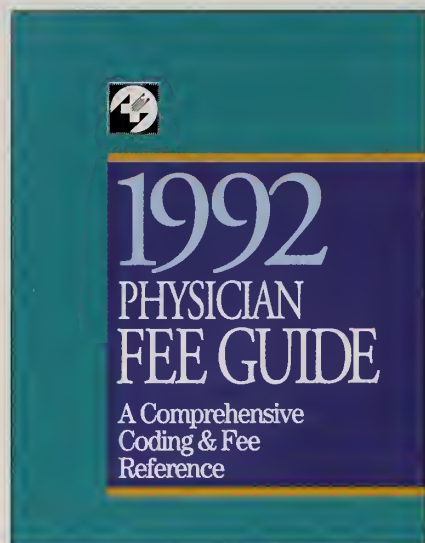


# SET YOUR RECORDS STRAIGHT

## 1992 Physician Fee Guide

The most comprehensive coding and fee guide available!

- Simplifies setting your fees for '92
- Valuable coding/billing tips including '91 and '92 codes
- Geographic adjustment factors for your locality
- Expanded surgical section
- Transition information (old codes to new codes)
- Simple, easy to use!



**HealthCare Consultants, Inc.** brings you a staff with over 50 years of experience to the area of medical practice management consulting, seminars and organizational management. Our new publications have been revised to reflect the vast changes in 1992 including the new CPT\* codes. You can relax and put our practice

management experience to work for you when dealing with the business aspects of your practice.

Other services offered by HCC, Inc. :

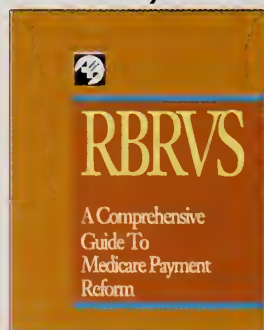
- Consulting & medical practice assessments in your office
- CPT/ICD-9 enhancement
- Billing/collections improvement
- Fee analysis
- Pre- and post-Medicare/Medicaid audit review
- Evaluation of computer needs
- Billing service

### Business Aspects of



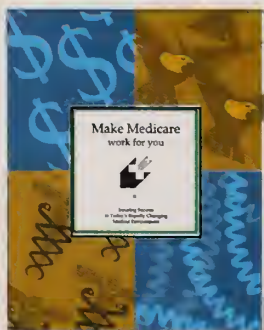
- Guide book of Office Management
- Marketing
- Personnel/internal controls
- Computers/medical records
- Appointment scheduling

### Physician's Guide to RBRVS



- What the final RBRVS rules *really* mean
- Identify billing opportunities under RBRVS
- Future impact in "plain English"
- One low-priced book-it's all you need to know about RBRVS

### Make Medicare Work for You



- What you need to know about Medicare law
- Legitimate billing opportunities
- Medicare check/coding tips
- How to handle denials, reviews, and appeals
- Secondary payer/other regulations

**For Information or to Order  
Call Toll-Free 1-800-253-4945!  
Fax 1-404-722-9869**

	QTY	TOTAL
<input type="checkbox"/> 1992 PHYSICIAN FEE GUIDE	\$99.95	_____
<input type="checkbox"/> MAKE MEDICARE WORK FOR YOU	\$39.95	_____
<input type="checkbox"/> BUSINESS ASPECTS OF MEDICAL PRACTICE	\$49.95	_____
<input type="checkbox"/> PHYSICIAN'S GUIDE TO RBRVS	\$49.95	_____
Ga. residents add 6% sales tax		_____
Shipping & handling		\$3.50
<b>TOTAL</b>		_____

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Telephone \_\_\_\_\_

VISA / M/C Acct. # \_\_\_\_\_

Exp.date: \_\_\_\_\_ Signature \_\_\_\_\_

\*CPT is a registered Trademark of the American Medical Association.



**HEALTHCARE CONSULTANTS, INC.**

609 Fifteenth Street • Augusta, Georgia 30901

themselves to the lofty ideals of our special calling and renew the faith of their younger years.

There is perhaps no greater sin of vanity than in quoting one's own words, but you have indulged my preaching for a year and I humbly beg one final indulgence before I leave you.

Here, in no particular order, are some of my observations during the year. I repeat them here less out of pride of authorship than out of my conviction that they are important to our profession—

“It is the solemn duty of every physician to involve himself in the concerns of his profession at the county, state and national levels. If we break faith with those who fought so long and hard to bestow on us the great blessings of private practice and professionalism, we will have betrayed a solemn trust and we will have broken the chain of centuries of professional advancement.

“We will suffer, our patients will suffer and we will have passed to our successors an extinguished torch. Is that the epitaph we want for our generation of doctors?”

—  
“We live in a time when the concept of commitment has been eroded by the seductions of materialism. In recent years, America has been so devoted to consuming, to getting and spending, devouring the substance of our posterity, the old-fashioned idea of commitment to any long-term and noble purpose has gone into eclipse. We have become a throwaway society; not only in material resources but in values and human relationships.

“Small wonder that our profession and its timeless commitment to patient care have been subjected to such relentless attack by the small-minded. What had once entitled us to respect, our dedication to healing, now invites ridicule in some quarters.”

—  
“What we have here is a classic study of a huge and powerful bureaucracy [HCFA] running amok and flagrantly usurping the legislative function. It was that act of brazen arrogance, more than anything else, that raised the hackles of Congress, jealous of its prerogatives even when it does not use them.... Too often in the past Congress has granted HCFA vague statutory authority with whispered instructions in the corridors to propose rule changes to accomplish an objective nowhere spelled out in the legislation itself....”

—  
“The ancient doctrine of noblesse oblige places a

heavy burden on the physician. It always has, for the simple reason that in return for our license to practice medicine, we make a solemn covenant with society ... to devote our time and talent, for life, in absolute dedication to our patients, forsaking all others.... Those among us who fail in this regard, fail all of us ....”

—  
“We should be proud parents of children who ... choose medicine and we should not be coy about saying so. Nor should we put them and the profession down by such remarks as we have all heard: ‘I warned him (her) that medicine has gone down the tubes. I told him (her) that it is not the great career choice it was when I made my decision. But he (she) wouldn’t listen’.... Cuss Washington and third-party payors all you like, but don’t badmouth medicine. If you have lost pride in your profession, at least don’t infect others with your affliction. Bear it in silence.”

—  
“In sum, the good doctor is accountable to his patient, to himself and to his profession, somewhat in that order. Following this simple catechism, he should never fall into serious error.”

—  
“Find ways to give more of your good fortune to your fellow man—increase significantly, and willingly, the fraction of free care you provide. Give more, much more, to worthy charities. Help some needy student through college or medical school. Get involved in community betterment programs....”

—  
“...The committed physician does not ask for political peace and tranquility, knowing these will not be his lot, but only for the serenity to do his job and keep his head when all about him seem to be losing theirs.”

—  
“... Whatever nonsense may fill the air, my wish is that you shall continue to find your greatest happiness in the totally dedicated practice of our science and art. That is the tradition handed down to us; it is the tradition we owe posterity....”

+++

I shall be forever grateful to you for the privilege of my year of stewardship in this never-ending cavalcade of medicine. Thank you, and Godspeed in your devotion to your patients, our profession and yourself.



# 'The Tort System Is The Problem'

*Howard C. Snider, M.D.*

April 20, 1992

Board of Directors  
Mutual Assurance, Inc.  
P.O. Box 590009  
Birmingham, AL 35259-0009

Gentlemen:

I was thrilled when I began reading the summary "Pathos or Profit" which I received from Mutual Assurance. The first page of the paper indicated that Mutual Assurance was studying alternatives to the tort system and would "soon put forth several proposals for major reform that will almost completely overhaul the way our patients resolve their disputes with physicians and hospitals." There was talk of "(making) the system work better for our patients..."

"At long last," I thought, "an entity with the clout to mobilize the forces to bring about meaningful reform has seen the light!" My hopes were dashed, however, when I read the attached memorandum, "Tort Reform: The Constitutional Approach," and realized that the proposal was to maintain the status quo of having a jury of uninformed lay people trying to decide whether malpractice has been committed. As you well know, the United States is the only country in the world with such a system. You say that "Without tort reform, the current system is badly flawed..." I would counter by offering that even with tort reform, the system is badly flawed, and a constitutional amendment mandating tort reform will not change that fact. The tort system is the problem. We do not need to reform it; we need to adopt a true alternative for malpractice claims.

Dr. Patricia Danzon, a health economist, crunched the numbers from the Medical Insurance Feasibility Study a few years ago and determined that of all the patients injured by medical malpractice less than 5% obtained any compensation whatsoever. The findings of the Harvard Study, an extensive review of over 30,000 charts in New York published in 1990, were identical. These were not patients who thought they

had been injured by negligence or whose attorneys claimed they had been injured. The charts were reviewed by unbiased medical personnel who determined that they had been injured by negligence, yet only 5% received so much as a dime of compensation. That problem cries out for reform, but your proposals can only make it worse.

You point out that medical/legal experts believe "the current tort system is sick—too sick to be fixed." One of the symptoms you cite is that "courts don't serve the patients who really merit compensation." I couldn't agree more. Please help me understand how caps on damages, periodic payout of awards, collateral source payment offsets, requirements for a "certificate of merit" in order to file a suit, accreditation of expert witnesses, "bifurcation" of trials, and the abolition of contingency fees (as meritorious as that suggestion may be) are going to help deserving patients obtain compensation. They clearly will not. They will only make it more difficult and will reduce the number of deserving claimants who obtain compensation even further below the deplorable 5%.

You claim that "Business managers, opinion leaders, union officials, and governmental regulators concerned with spiraling health care costs are finally beginning to understand that the defensive medical practices induced by the current Tort System's malpractice litigation crisis are a primary driving force." However, you correctly admit that "there has been no measurement of MICRA's effect on the steadily rising costs of medical or hospital services." There is no evidence that MICRA, California's landmark tort reform act (or any other tort reform, for that matter), had any effect on the practice of defensive medicine. I can tell you with absolute assurance that Alabama's tort reform laws had no impact whatsoever on my defensive practice or with that of any of the countless Alabama doctors who have discussed it with me. Doctors do not practice defensively because they are concerned about contingency fees, periodic payment or awards, collateral source payments and the like. They practice defensively because they know their cases will be presented to a jury of lay people to decide whether they are guilty of malpractice. They will continue to do so until their fates are decided in a

**THE UNITED STATES ARMY RESERVE  
HEALTH CARE PROFESSIONALS  
BONUS TEST PROGRAM  
\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**



more rational manner.

Any solution to our malpractice litigation problem which does not address and correct the inadequate compensation to deserving patients cannot be long lasting. It is a waste of time, energy and money to mount a campaign for shortsighted, self-serving "reform." There are many proposals which would provide better compensation to patients, including mandatory arbitration and administrative agencies. The proposal offered by the American Medical Association and the 31 specialty societies even offers to pay a state which is bold enough to adopt the plan. If we can convince the voters that a panel of "health professionals, lawyers, economists, and business persons" can do a better job than a jury of deciding how much an award should be, we can convince them that a similar panel can do a better job of deciding whether there has been malpractice.

You make the claim of your proposal that, "because it preserves elements of the present system, it should be less expensive than proposals that call for a sweeping overhaul of the entire tort system." I disagree. The greatest expense of the current system is the \$20 billion annual cost of defensive medicine. Add that to the \$10 billion in malpractice premiums paid by doctors and hospitals and you see that our current system costs \$30 billion a year. Your proposal would do nothing to curtail the cost of defensive medicine. A proper "sweeping reform" could virtually eliminate it. The Midwest Institute of Health Care and Law estimates that 100% of patients injured by "probable negligence" could be compensated by an administrative agency for about \$5 billion a year. Which is better, compensating 5% of patients for \$30 billion or 100% of patients for \$5 billion? The choice is clear.

As a stockholder in Mutual Assurance, I request that you not squander my money on a campaign that can only harm my patients and delay the inevitable day of reckoning when we are forced to abandon our "us against them" mentality. Count me in only when you are ready to work toward reform which will truly be in the best interest of our patients and will offer the promise of being a longlasting solution to the problem.

Sincerely,  
Howard C. Snider, M.D.  
Montgomery

# YOCON®

## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

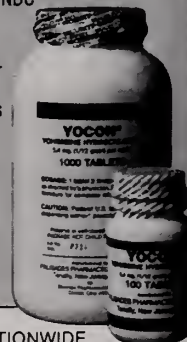
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES  
PHARMACEUTICALS, INC.**

219 County Road  
Tenafly, New Jersey 07670  
(201) 569-8502  
1-800-237-9083

# The ACCUPRIL Single-Agent Commitment<sup>TM</sup>

Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.\*†



New!  
ONCE-A-DAY ‡  
**ACCUPRIL<sup>®</sup>**  
quinapril HCl tablets 10, 20, 40 mg



\* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.



## Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

### INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

### CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

### WARNINGS

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately; the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

**Hypotension:** Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

**Fetal/Neonatal morbidity and mortality:** ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilate.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at  $\geq 25$  mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

### PRECAUTIONS

#### General

**Impaired renal function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

**Evaluation of hypertensive patients should always include assessment of renal function** (see DOSAGE AND ADMINISTRATION).

**Hyperkalemia and potassium-sparing diuretics:** In clinical trials, hyperkalemia (serum potassium  $\geq 5.8$  mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

**Surgery/anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients

**Angioedema:** Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

**Symptomatic hypotension:** Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

**Hyperkalemia:** Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

## Accupril® (Quinapril Hydrochloride Tablets)

**Neutropenia:** Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

### Drug Interactions

**Concomitant diuretic therapy:** As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

**Agents increasing serum potassium:** Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

**Tetracycline and other drugs that interact with magnesium:** Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

**Lithium:** Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

**Other agents:** Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

### Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m<sup>2</sup> basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilate were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 clonal lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively).

#### Pregnancy

**Pregnancy Category D:** See WARNINGS, Fetal/Neonatal morbidity and mortality.

#### Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

#### Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinapril compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

#### Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

#### ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

#### Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in *italics*) include (listed by body system):

**General:** back pain, malaise

**Cardiovascular:** palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

**Gastrointestinal:** dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

**Nervous/Psychiatric:** somnolence, vertigo, syncope, nervousness, depression

**Integumentary:** increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

**Urogenital:** acute renal failure

**Other:** amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

**Angioedema:** angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

#### Clinical Laboratory Test Findings

**Hematology:** (See WARNINGS)

**Hyperkalemia:** (See PRECAUTIONS)

**Creatinine and blood urea nitrogen:** Increases ( $>1.25$  times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

\* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



Division of Warner-Lambert Company  
Morris Plains, New Jersey 07950



# National Health Care Reform

## The Aura of Inevitability Intensifies

By George D. Lundberg, M.D.  
Editor, JAMA

Copyright 1992, American Medical Association\*  
Reprinted with permission

Major political change in a democratic republic such as ours comes about when a cluster of forces temporally coalesces to form a critical political mass of sufficient strength to power that change. Sometimes, tangential, seemingly unrelated events create that coalescence although the need for such change, people wanting it, and the resources necessary to produce it were long present. So it is with national health care reform in this country.

In my opinion, five salient events have brought health care reform to the forefront of the US national agenda:

1. The nasty recession that began in 1990 and has lingered into 1992, causing large numbers of politically active voters without adequate health insurance to join the politically impotent poor in insisting on reform.

2. The expanding tragedy of the AIDS epidemic, which created a large new group of highly educated and financially secure individuals who became economic paupers on their way to death as a result of underinsurance for their catastrophic illness.

3. The publication by the Scientific Publications group of the American Medical Association (AMA), representing the medical establishment, of nearly 100 articles in our 10 journals in May 1991, giving ample reason for demanding significant health care reform.<sup>1</sup> Most of the articles were written by physicians; no longer could the Washington political establishment blame the doctors for preventing reform.

4. The disintegration of the Union of Soviet Socialist Republics following collapse of the Warsaw Pact, the Iron Curtain, and the Berlin Wall. These cataclysmic events, of almost biblical proportions, pre-empted, at least for now, our nation's long-term pre-occupation with massive defense attention and expenditure.

5. The sudden death of Sen. John Heinz of

Pennsylvania in an airplane crash in 1991. President George Bush hand-picked then-Attorney General Richard Thornburgh to run for that senatorial position. The Democratic candidate, Harris Wofford, who had never held political office, was elected, largely on the basis of his outspoken advocacy for a national health care plan. Shortly thereafter, White House Chief of Staff John Sununu departed, and in February 1992, the Bush administration joined the national health care reform debate 1 week before the first presidential primary.

Many other things have happened, involving many other people, but I believe these are the five keys that unlocked the debate on health care reform.

### May 1991

The May 15, 1991, *JAMA* and the compendium<sup>1</sup> of articles from the AMA's nine specialty journals stimulated intense media coverage that has not abated. This effort on behalf of the uninsured contributed to breaking the American political logjam. We continue to publish articles on caring for the uninsured and underinsured and to give frequent speeches and television presentations. Movement in the direction of solution has been gratifyingly rapid.

In this anniversary week of *JAMA's* first health care reform issue we revisit the subject, with analysis and recommendations. The complex nature of reform is much better understood now than it was a year ago by the public, the profession, and the politicians. But national health care reform has been correctly called the most complicated issue to face US policymakers since the Great Depression.

At least 57 national and state legislative proposals for health care reform have been filed; major components of the Republican and Democratic platforms will deal with health care reform. Presidential contenders have already developed their postures regarding health care reform. It is now time for some decisions. A comprehensive, but brief, apolitical analysis

---

\*JAMA, May 13, 1992—Vol. 267, No. 18, pp2521-2524.



# A#

NEW INDICATION

## ONLY ONE H<sub>2</sub>-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H<sub>2</sub>-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150 mg b.i.d.**, relieves heartburn in **86%** of patients after one day and **93%** after one week.<sup>1</sup>

**AXID**<sup>®</sup>  
nizatidine  

---

150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

# AXID<sup>®</sup>

## nizatidine capsules

**Brief Summary.** Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlorzazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2993 AMP

[101591]

Additional information available to the profession on request.

**Eli Lilly and Company**  
Indianapolis, Indiana  
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY



by Blendon et al<sup>2</sup> of all the major serious proposals appears in this issue to help educate as many people as possible and move the debate forward with clearer understanding.

With President Bush having entered the discussion, the reality of reform seems assured. The only questions now are what, how much, how soon, how incremental, how complete, how effective, and how long-lasting.

## Value for Money

Since the year 1900, we Americans have added 7 hours to the average life expectancy at birth for every 24 hours lived—an incredible modern achievement.<sup>3</sup> Of this we as a civilization should be extremely proud. But a look at Fig. 1 demonstrates that the major gains were in the first several decades when expenditures were low, while in the middle and latter portions of the century, the slope has been much more gradual. Figure 2 allows comparison of that simple outcome measure (life expectancy) with the amount of money invested in medical and health care in this country as measured by the percentage of the gross national product. It signals an entirely different perspective. Whether or not there is cause and effect, there seems to be little relationship between the percentage of gross national product spent on medical and health care and the extent of improvements in expected life span. Is there any wonder why many doubt that we are providing value for money?

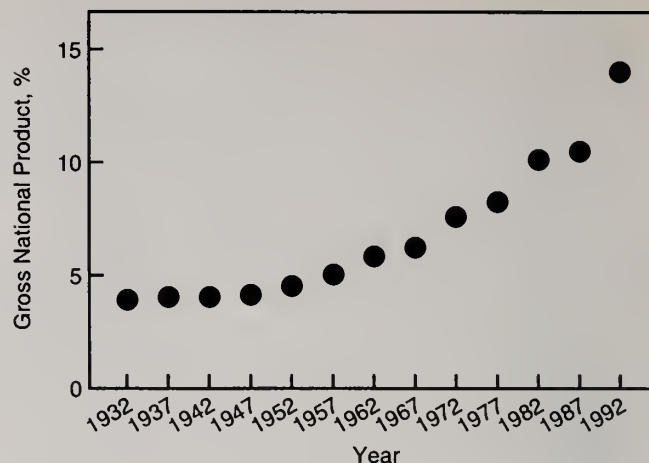
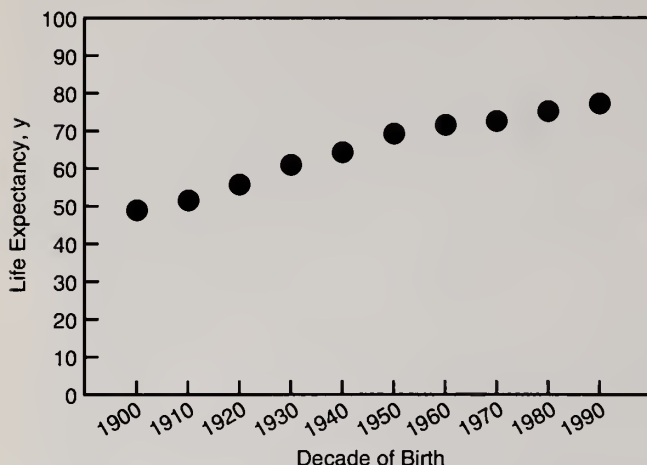
## The Characteristics of Successful Health Reform

What is the grid on which all proposed programs must be stretched and tested (Table)?

**Providing Access to Basic Medical Care for All of Our People.**—An accepted definition of basic medical care has been difficult to establish. The term is subject to everyone's personal value judgment. Two widely differing but excellent frames of reference are the basic benefits package approved as policy by the AMA House of Delegates and the Oregon Health Decisions list of 709 treatment plans. The AMA plan has the benefit of clarity, simplicity, and broad support. The Oregon plan has the advantage of a stepwise prioritization of services, created by professionals and grass roots individuals based upon the judgment of benefit vs. costs.

As long as we are in a free society with medical pluralism, providing access means that there must be insurance coverage for all, either paid for by individ-





**Fig 1.**—Expectation of life by decade of birth in the United States. Continuous steady progress seems poorly related to financial expenditures.

**Fig 2.**—Percentage of the gross national product expended for medical and health care in the United States. The trend moved from asymptotic to the horizontal to nearly asymptotic to the vertical.

uals (or families), by employers, by government, or by some combination thereof. But, insurance alone is not enough. There must also be education regarding the availability of care, attempts to remove cultural and language barriers that would prevent adequate care, provision of local resources (or transportation to appropriate facilities), and the abolition of racial discrimination as it manifests itself in health care provision. If we retain a system of private health insurance, such insurance must be community-rated and not risk-rated,<sup>4</sup> must be available to all without consideration of preexisting conditions, must be transportable by the insured, available to all US inhabitants (or covered by government), and affordable. If all of these conditions cannot be met, then private insurance for the general populace should cease to exist for basic medical care and should be confined to individually purchased "boutique" care.

Payment for providing access for all can be made available by promptly effecting cost controls that slow the anticipated increase in expenditures for health care.<sup>5</sup>

**Producing Real Cost Control.**—Without real cost control, successful health care reform cannot happen. The slope of costs for medical and health care in this country, as expressed in the percentage of gross national product expended on medical and health care, has changed from asymptotic to the horizontal to nearly asymptotic to the vertical in the course of my lifetime (Fig 2). Obviously, this extreme is unacceptable. During the burgeoning scientific revolution

of the 20th century, to increase the amount and percentage of resources spent on medical and health care was entirely valid. But now health care costs have reached a doubling time of less than 5 years. Earlier articles have itemized the reasons for these out-of-control costs and proposed many solutions.<sup>5,6</sup> A mixture of several solutions is probably the best answer. I believe that the following steps should be taken to control costs.

- Clearly futile care should cease.
- Unnecessary and inappropriate care should stop.
- Self-referral to physician-owned facilities should be eliminated.
- The tort system of liability should be reformed.
- Managed care and managed competition should be drastically expanded.
- All Americans should have a primary care physician to function as caregiver, patient advocate, adviser, and medical manager-gatekeeper for access to specialty care.
- We should retain a private-public mix of payers and the health care industry.

Even if all of this is done, I agree with Ginzberg<sup>7</sup> that we still must have some form of global budget that curtails the flow of new money from government and insurers. Excess capacity and utilization must be limited and a ceiling established no matter how distasteful or politically dangerous that may seem to be. To fairly set such global budgets (by state or nationally) it will be necessary to legislate a national health expenditure board, with independent authority to

# COMMITTED TO EXCELLENCE

*Roche  
Laboratories  
presents the  
winners of  
the 1991*



Please join us in honoring these outstanding Roche sales representatives who have distinguished themselves by a truly exceptional level of professionalism, performance and dedication to quality health care.

Throughout the year, each of these award-winning individuals has consistently exemplified the Roche Commitment to Excellence, and we're proud to invite you to share in congratulating them on their achievement.



Hayes A. Salley



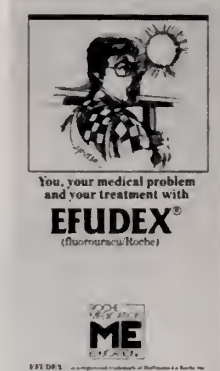
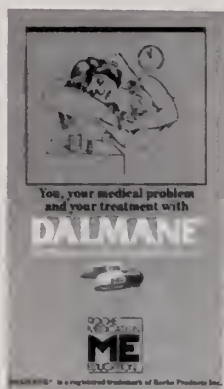
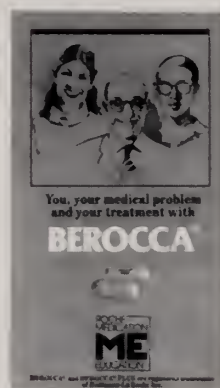
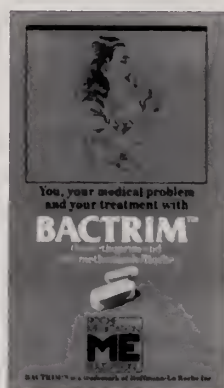
William Phillip Wiggins



# COMMITTED TO TOTAL HEALTH CARE

*Roche  
Laboratories  
presents the  
Resource Library  
for patient  
information*

ROCHE  
**ME**  
MEDICATION  
EDUCATION

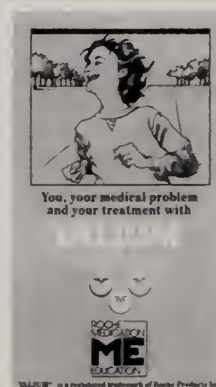
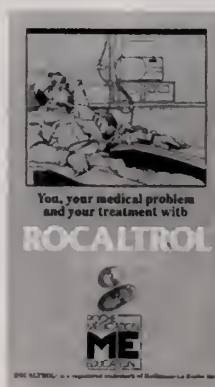
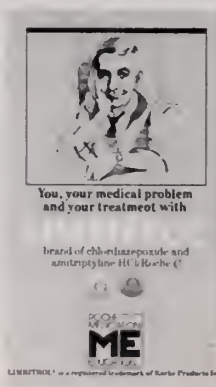
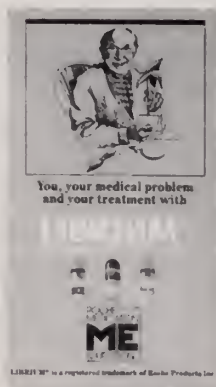


Your Roche representative offers you access – without expense or obligation – to a comprehensive library of patient information booklets designed to supplement rather than supplant your rapport with your patients.

Each booklet helps you provide...

- Reinforcement of your instructions
- Enhancement of compliance
- Satisfaction with office visits

Your Roche representative will be happy to provide a complete catalog of available booklets and complimentary supplies of those that are applicable to your practice.



## The Grid Upon Which to Test Health Care Reform Proposals

Does the proposal achieve the following:

- Provide access to basic medical care for all of our people?
- Produce real cost-control?
- Promote continuing quality?
- Limit professional liability?
- Reduce administrative hassle?
- Retain necessary patient and physician autonomy?
- Consider long-term care?
- Encourage primary care?
- Enhance disease prevention?
- Possess staying power after 5, 10, or 20 years?

effect such decisions.

**Promoting Continuing Quality.**—Quality is best defined as the totality of features and characteristics of a product or a service that plays on its ability to satisfy given needs. For those intelligent and literate individuals with strong comprehensive health care insurance, our quality of care is as good as the best in the world. Preserving this quality in an era of harsh economic constraints will provide a major challenge. Active use of practice guidelines/parameters and outcome measurements should allow us to preserve quality. Government and the people will rely on the professionalism of physicians to defend the quality of care given those for whom they have specific responsibility.

**Limiting Professional Liability.**—The costs of malpractice coverage and defensive medicine are unknown but very large—perhaps in excess of \$20 billion per year.<sup>8</sup> Defensive medicine probably benefits no one except these with the health care jobs that are generated. Only about half of the total fiscal resources placed into the malpractice insurance pool ever find their way to truly injured patients. The remainder is consumed by “friction costs” of investigators, administrators, insurance companies, expert witnesses, lawyers, and courts. This grossly unfair and inefficient situation must be solved as part of health care reform.

**Reducing Administrative Hassle.**—Everyone admits that the current system is rife with administrative waste, inefficiency, and a ubiquitous “hassle factor.” Physicians and their office staffs could be greatly benefited by elimination or at least serious diminution of unnecessary hassles. Such absurdities as billing

Medicaid several times to receive a single minuscule payment months later or forcing a competent physician to call a nonphysician somewhere to authorize a needed routine service for an ill patient must be replaced.

**Retaining Necessary Physician and Patient Autonomy.**—Who is in charge? The patient, whose life it is? The physician, whose professionalism it is? Or the payer, whose money it is? They all are, and it is at this interface of values that the medical ethicist of the future will be most active. Patients and physicians must both retain substantial autonomy. Each health care reform proposal must be scrutinized to assess the extent to which all parties’ essential rights are compromised, and value judgments must be deliberately and openly debated so that informed decisions can be made in advance.

**Considering Long-term Care.**—Aside from access for all and real cost control, the most vexing element in this whole conundrum probably is long-term care. Since we are, in effect, victims of our own success, the very old (those over 85 years old or even over the age of 100) comprise the most rapidly growing segment of our population. Many need long-term care. And if the Boston study,<sup>9</sup> which documented a 47% incidence of Alzheimer’s disease in our population over age 85, is validated by other studies, we are really in trouble economically. Medicaid costs are stressing virtually every state’s budget, and long-term care is a major element of that expense. The private health insurance sector has barely scratched the surface on providing comprehensive long-term care coverage for a significant proportion of our population. It may be in this area that the most wrenching, end-of-life ethical policy decisions await us.

**Encouraging Primary Care.**—Our system of allowing individual physicians freely to choose the field they will enter has been terrific for individual physicians but a mass catastrophe for the country. The incentive/disincentive of paying much for procedures (whether or not they are needed or effective) and little for primary care has discombobulated supply and demand. We now have about 615,000 physicians; 65% are in specialty care and 35% in primary care. The principles other developed countries practice are that the proportion of primary care physicians and specialists should be about 50-50, and all individuals should have a primary care doctor whom they see first. We need to retrain about 100,000 specialist physicians as competent primary care physicians and have them practice as such. Only financial incentives and disincentives will likely be strong enough to



motivate that profound shift. Obviously, trained specialists will not be clamoring to become primary care physicians, at least not soon.

**Enhancing Disease Prevention.**—The massive funding now going toward futile care or care for those with preventable full-blown disease should be redirected to prevention. We should begin paying doctors more for preventing diseases and less for treating them. No restrictive copayments or deductibles should be applied to retard use of proven preventive measures such as Papanicolaou tests, mammograms, vaccinations, and prenatal care.

**Possessing Staying Power After 5, 10, or 20 Years.**—Our last major national health care reform occurred 27 years ago, with enactment of Medicare and Medicaid legislation. We must be prepared to live with the next set of major reforms for a substantial number of years—but not forever. We should strive to enact legislation with a successful use-life of at least 10 years. Analyses that realistically project the effects of proposed legislation at 5, 10, or even 20 years from enactment are an absolutely essential component of this debate and these deliberations. And methods for continuing evaluation and mid-course adjustments should be put into place with initial legislation.

Of course, maintaining our tradition of great strengths in medical education and research is also crucial during and after reform.

### **Preventing the 1990s Health Care System Meltdown**

During the greedy 1980s, we as a society experienced, in addition to all-time record federal budget and international trade deficits, an embarrassing savings-and-loan debacle, and a Wall Street junk bond collapse. Each was predictable and preventable, and each, because it was not prevented, has had massive long-term economic federal budget implications.

We are now poised near the brink of what I call the 1990s health care system meltdown. Our doubling time for health care expenditures is now less than 5 years. We are looking at potential health care expenditures in 1992 dollars of \$1.4 trillion by 1996. I do not believe our economy can tolerate these costs. If business continues as usual without major change, I predict meltdown by 1996. At that point, in a worst-case scenario, the Congress would panic and nationalize the entire health care industry; they can do that. The physicians, nurses, pharmacists, and other health care workers would be conscripted as government employees; hospitals would be taken over and run by the government; health insurance companies would

be abolished; the pharmaceutical and medical device industries would be nationalized. I believe that such an event would be tragic, catastrophic, and certain to fail over time. I cannot imagine a government monopoly of that size succeeding.

But I believe that medicine is different from the savings-and-loan and Wall Street businesses. I believe that physicians are professionals. We know that true professionalism means self-governance, self-determination, and ethical behavior in the public interest. To merit still being called professionals, we physicians will have to prevent the anticipated meltdown in advance, by proper preventive, scientific, educational, and political action—now.

### **Benefits for Physicians**

In successful health care reform, all players and all stakeholders will have to compromise—the patients, the physicians, the insurance companies, the hospitals, the government, the politicians, and all the special interest groups. But the essence of compromise means that the major players all give up something and get something. The current US health care reform movement, if successfully negotiated, can benefit physicians through (1) malpractice tort reform, (2) decreased hassle factor, (3) elimination of uncompensated care, (4) ability to practice medicine of high quality, (5) improved public image, and (6) pride in their professionalism.

### **Physicians—The Champions of Change**

American physicians are champions of change. There has been more change since the year 1900 than in the entire preceding course of human history. Much of that change has been in medical and surgical information and clinical actions. Little of the technology now routinely used by physicians was invented, or even conceptualized, when I was in medical school in the 1950s.

This past decade manifested enormous change in medical practice patterns, in social economics, and in government decisions. The implementation of diagnosis related groups, managed care in many segments, the resource-based relative value scale, and the impending Clinical Laboratory Improvement Amendments are examples. We as a profession have encountered, participated in, and succeeded in each of these revolutions. But these changes, momentous though they may have seemed at the time, were mere

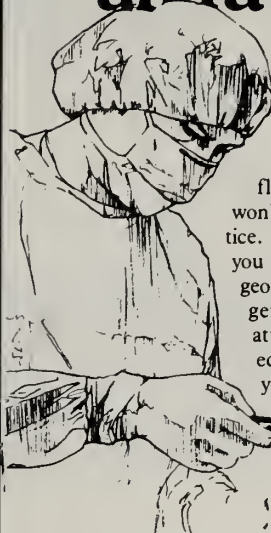
pilot tests—warm-up exercises—for the changes that lie ahead of us.

Most physicians are concerned about the future, many are apprehensive, some are afraid. But, as a group, we are very smart, very well educated, very highly motivated, very well organized and led, and ready for any challenge. With all of these positive characteristics and outstanding ongoing communications, as long as we continue to place the interests of patients and the public first, we shall prevail.

George D. Lundberg, MD

1. Springer MD, Lundberg GD, eds. *Caring for the Uninsured and Underinsured*. Chicago, Ill: American Medical Association; 1991.
2. Blendon RJ, Edwards JN, Hyams AL. Making the critical choices. *JAMA*. 1992; 267:2509-2520.
3. Foegen WH. Expanding the boundaries of medicine: targeting a common enemy. *JAMA*. 1991;266:7022503-2508.
4. Light D. The practice and ethics of risk-rated health insurance. *JAMA*. 1992;267: 2503-2508.
5. Lundberg GD. National health care reform: an aura of inevitability is upon us. *JAMA*. 1991;265:2566-2567.
6. Lundberg GD. The high cost of health. GAO J. Summer/fall 1991:7 8.
7. Ginzberg E. Managed care has not lived up to its promises. *New York Times*. February 20, 1992.
8. Reynolds RA, Rizzo JA, Gonzalez ML. The cost of medical professional liability. *JAMA*. 1987;257:2776-2781.
9. Evans DA, Funkenstein HH, Albert MS, et al. Prevalence of Alzheimer's disease in a community population of older people. *JAMA*. 1989;262:2551-2556.

# An Officer and a Surgeon



If you're a surgeon looking for a change of pace and a chance to sharpen your surgical skills, try your hand in the Air Force Reserve. Serve part-time. Our flexible participation schedule won't interfere with your private practice. Depending on your experience, you may qualify for the Flight Surgeon Program. As an officer, you'll get good pay, benefits and paid attendance to continuing medical education (CME) activities. Serve your country. Serve yourself. For more information, call (404)421-4892. Today's Air Force Reserve...it's a great way to serve.

AIR FORCE RESERVE

14-214-0004 A GREAT WAY TO SERVE

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992

Above rates are provided by Jackson National Life



# Newly Licensed Doctors

McClay, John Eric, M.D.  
UAB/Division Otolaryngology  
1501 5th Avenue South  
Birmingham, AL 35294

Dedios, Frine Escalona, M.D.  
Baptist Medical Center-DeKalb  
200 Medical Center Drive  
Ft. Payne, AL 35967

Thomas, Clinton Lavern, Jr, M.D.  
700 Gause Boulevard, Suite 206  
Department Ob-Gyn  
Slidell, LA 70458

Lyman, John Leslie, M.D.  
1140 Magnolia Avenue  
Emergency Medicine  
Panama City, FL 32401

Bartholomew, Deborah Ann, M.D.  
USAMC / Department Ob-Gyn  
P. O. Box 40400  
Mobile, AL 36640

Kremchek, Timothy Edward, M.D.  
63 Clearwater Road  
Department Orthopaedic Surgery  
Newton Lower Falls, MA 02162

Downs, David Michael, M.D.  
615 Perkins Street  
General Practice  
Ft. Benning, GA 31905

Culpepper, Richard Dale, M.D.  
AL Clinic Orthopaedic Surgery &  
Sports Med  
115 Manning Drive, SW, Ste. A-101  
Huntsville, AL 35801

Dabbs, Randal Lee, M.D.  
Humana Hospital - Muscle Shoals  
201 Avalon Avenue  
Muscle Shoals, AL 35661

Alford, David Wiley, M.D.  
UAB/Orthopaedic Surgery  
619 South 19th Street  
Birmingham, AL 35233

Atkinson, Monica Wendy, M.D.  
4713 King Fisher  
Houston, TX 77035

Ballesteros, Oswaldo, M.D.  
16 Buena Vista Drive  
Murphysboro, IL 62966

Barreto-Sola, Luis Ramon, M.D.  
61 Delfos Street Apola  
Guaynabo, PR 00969

Bowman, Michael Dewitt, M.D.  
Mostellar Medical Center/Ob-Gyn  
12701 Padgett Switch Road  
Irvington, AL 36544

Cook, Anthony Brian, M.D.  
Anesthesia Services of Birmingham,  
PC  
P. O. Box 530590  
Birmingham, AL 35253

Cook, Judith Anne Hamann, M.D.  
3001 Scenic Highway  
Department Psychiatry  
Gadsden, AL 35901

Crawford, Vinton Anthony, M.D.  
308 West Hickory  
Department Urology  
Sylacauga, AL 35150

Cronin, Kelly Grace, M.D.  
2387 Perth Drive  
Department Pediatrics  
Orange Park, FL 32065

deSolo, Santiago Miguel, M.D.  
UAB/Department Rheumatology  
1813 6th Avenue, South, MEB 625  
Birmingham, AL 35294

Eldridge, Charles Edward, M.D.  
Andalusia Hospital/Dept. Pediatrics  
P.O. Box 760  
Andalusia, AL 36420

Fockele, Daniel Sherman, M.D.  
Anniston Radiology Group, PC  
108 Medical Arts Building  
Anniston, AL 36201

Givens, Timothy Gerard, M.D.  
Children's Hospital/Pediatric  
Emergency Med.  
1600 7th Avenue South  
Birmingham, AL 35233

Goodwin, Timothy Brian, M.D.  
363 West Byron Avenue  
Department Internal Medicine  
Mobile, AL 36609

Haddad, Imad Yacoub, M.D.  
Children's Hospital/Pediatric Critical  
Care  
1600 7th Avenue, South  
Birmingham, AL 35233

Hicks, Jennifer Olivia, M.D.  
2002 Medical Center Drive  
Department Ob-Gyn  
Bay Minette, AL 36507

Hollowell, Weems Opie, M.D.  
175 Harborage Court  
Department Neurosurgery  
Clearwater, FL 34630

King, Walter Leslie, Jr., M.D.  
Radiology Associates of Dothan, PA  
1900 Fairview Avenue  
Dothan, AL 36301

Mallett, Presley Donald, M.D.  
201 Cox Street  
Department Anesthesiology  
Mobile, AL 36604

Matovu, Sarah Musoke, M.D.  
1117 Tuscaloosa Avenue  
Gadsden, AL 35901

Nanda, Navin Chandar, M.D.  
UAB/Department Cardiology  
UAB Station, SWB/S102  
Birmingham, AL 35233

Newton, Randall Booth, M.D.  
UAB/Department Diagnostic Radi-  
ology  
619 South 19th Street  
Birmingham, AL 35233

# 1-800-AMA-3211

## Think of it as 9-1-1 for America's health care system.

Today, a number of Americans think the answer to our health care problems is a single-payor, national system.

Thankfully, a number disagree. They think that our current system needs to be reformed. Not replaced. They're your peers in the American Medical Association, who support Health Access America. And they're your patients.

Health Access America comes to the rescue with a plan to improve programs such as Medicare and Medicaid, and to require employer-sponsored health insurance, without sacrificing the strengths of the current system.

So if you number among those who want reform, call for help. Call for the kind of changes that will benefit all Americans. Call 1-800-AMA-3211 for more information on Health Access America.

### Health Access America

The AMA proposal to improve access to affordable, quality health care.

### American Medical Association

Physicians dedicated to the health of America





Philp, Elizabeth Beatson Forbes, M.D.  
UAT/Department Family Practice  
Box 820326  
Tuscaloosa, AL 35487

Philp, James Ramsay, M.D.  
Department of Medicine  
UAT/College of Health Sciences  
Tuscaloosa, AL 35487

Rankine, David Andrew, M.D.  
Northeast Alabama Neurological Services, PC  
1820 Leighton Avenue  
Anniston, AL 36202

Respicio, Eusebio Salvallon, Jr., M.D.  
Searcy State Hospital/Psychiatry  
P.O. Box 1001  
Mt. Vernon, AL 36560

Roy, Reverly Jane, M.D.  
USAMC / Pediatrics-Neonatology  
2451 Fillingim Street  
Mobile, AL 36617

Ruggiero, Peter, M.D.  
Medicine Clinic  
Noble Army Hospital  
Ft. McClellan, AL 36205

Smith, Mark Glendeaux, M.D.  
3600 Plymouth Road  
Louisville, KY 40207

Sutton, William Roger, M.D.  
Hughston Sports Medicine Hospital  
100 First Court  
Columbus, GA 31995

Ticas, Roberto A., M.D.  
Renal Hypertension Clinic, PC  
1404 East Main Street  
Dothan, AL 36301

Wade, Patricia Ann, M.D.  
Internal Medicine Associates, PC  
121 North 20th Street  
Auburn, AL 36802

Walker, Rosalyn Clark, M.D.  
6116 Lake Trace Circle  
Department Pediatrics  
Jackson, MS 39211

West, Penny Chumney, M.D.  
612 Vinings Parkway  
Department Internal Medicine  
Smyrna, GA 30080

Wilensky, Michael Keith, M.D.  
801 Princeton Avenue, SW  
Department Cardiology  
Birmingham, AL 35211

Fuller, Richard, M.D.  
Simon-Williamson Clinic, PA  
833 Princeton Avenue, SW, Internal Medicine  
Birmingham, AL 35211

Austin, James Randall, D.O.  
Montgomery Internal Medicine Program  
4240 Narrow Lane Road  
Montgomery, AL 36111

Saunders, Jan Edwin, D.O.  
434 West Grand Avenue, Apt. 49-E  
Department Orthopaedic Surgery  
Dayton, OH 45405

Walker, Barbara Elaine, D.O.  
P.O. Box 13588  
Department Family Practice  
RTP, NC 27709

Parzynski, Pamela Ann, D.O.  
Cardiothoracic Anesthesia Assocs.  
Huntsville  
925-D Franklin Street  
Huntsville, AL 35801

Cannon, Adam David, M.D.  
UAB/Division Cardiovascular Diseases  
UAB Station—LHRB Room 316  
Birmingham, AL 35294

Carcelen, Roxana Isabel, M.D.  
UAB /Pulmonary-Critical Care Unit  
1900 University Boulevard, 215 THT  
Birmingham, AL 35294

Dorey, Jason Hollister, M.D.  
2400 Mellwood Avenue, Apt. 809  
Dept Diagnostic Radiology  
Louisville, KY 40206

Fierra, Jeffrey James, M.D.  
21764 Montclare Boulevard  
Radiology & Occupational Medicine  
Strongsville, OH 44136

Murray, Brian Philip, M.D.  
#3 425 West Junipero  
Department Anesthesiology  
Santa Barbara, CA 93105

Salna, Jonas Romas, M.D.  
2425 Eraste Landry, 104-A  
Department Internal Medicine  
Lafayette, LA 70506

Shoemaker, Russell Lowell, D. O.  
Southeast Alabama Medical Center  
Attn: External Development  
P.O. Drawer 6987  
Dothan, AL 36302

Friedel, Robert O., M.D.  
UAB/Department Psychiatry  
1700 7th Avenue South  
Birmingham, AL 35294

Hook, Edward Watson, 111, M.D.  
UAB/Infectious Diseases  
UAB Station, THT 229  
Birmingham, AL 35294

Hutchins, Bob W., M.D.  
1505 Lincoln Avenue, SW  
Department Emergency Medicine  
Birmingham, AL 35211

Park, Yung Jee, M.D.  
UAB/Department Pathology  
UAB Station, Kracke Building, Rm 726  
Birmingham, AL 35294

Saif, Mai Frieda, M.D.  
6811 Old Canton Road, #5404  
Department Radiology  
Ridgeland, MS 39157

# FREEDOM FROM PAIN!

**Extra strength pain relief  
free of extra prescribing  
restrictions.**

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

## Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

## The heritage of VICODIN<sup>®</sup>,\* over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin ES** 

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)



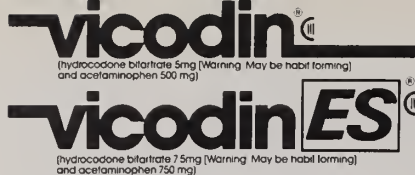
**Tablet for tablet, the most potent analgesic you can phone in.**

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit





**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

**WARNINGS:**

**Allergic-Type Reactions:** VICODIN/VICODIN ES Tablets contain sodium metabisulfite, a sulfite that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people.

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**PRECAUTIONS:**

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

**Usage in Pregnancy:**

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:**

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

**DRUG ABUSE AND DEPENDENCE:**

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

**OVERDOSAGE:**

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

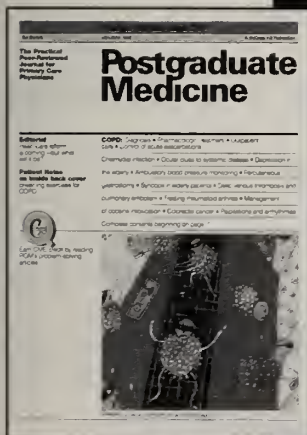
**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by McQuick Print, formerly MASA Services. Communications should be addressed to *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-239-MASA.



## US THEM



**Postgraduate  
Medicine**

**WHEN YOU NEED  
TIME ON YOUR  
SIDE, THE CHOICE  
IS CLEAR.**

**NO CLINICAL  
CLUTTER—  
PGM ARTICLES  
ARE CLEAR,  
CONCISE, WELL  
ILLUSTRATED,  
AND PRACTICAL.**

## Debt Collection Essential In Sour Economy

### I.C. System

Are you having difficulty with your accounts receivable? That's not surprising in today's weak economy. The recession has left red ink stains on many businesses' books as overdue bills go unpaid. Moreover, our stagnant economy does not show many signs of coming to life soon, even in this election year.

Although you might think that collection agencies are swamped in recessionary times like this, the agency that our association endorses says that this is not true. According to I.C. System, inc., creditors are tending to hang onto their bills longer before submitting them, because they want to try collecting the delinquent accounts themselves. Unfortunately, this rarely works. If a debtor has not paid you by the time the bill is 90 days overdue, there is little likelihood he ever will without the help of a third party. According to the American Collectors Association, only five percent of accounts over 90 days delinquent are paid voluntarily. This is where I.C. System's assistance can be invaluable. The sooner you submit your accounts to I.C. System, the more successful you will be in collecting the money that's owed you.

There's another urgent reason for sending your delinquent accounts to I.C. System immediately: tax refunds. Your debtors may be receiving tax refund checks from Uncle Sam and their state governments. If your accounts are being actively collected when the refund money arrives, I.C. System may be able to settle many of your past-due accounts now. It's timing that counts! Don't miss this opportunity to have your debts collected while debtors have increased cash flows.

To take advantage of tax time, I.C. System strongly recommends that you gather your overdue accounts and submit for collection just as soon as possible. Then, make it a practice in the future to turn in all accounts regularly once they become 60-to-90 days delinquent. As accounts age, they become less and less collectable. Delaying longer than 90 days quickly reduces the value of debts, as much as 1/2 percent a day.

In addition to our association, I.C. System is endorsed by almost 1,200 other business, trade and professional organizations. It was established in 1938 and serves clients in all 50 states. If you aren't currently using I.C. System's effective and ethical services, you can get more information about this company by contacting our association office or by calling I.C. System at 1-800-325-6884.





## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

\* Registered Marks Blue Cross and Blue Shield Association

# A Procedure To Assist Impaired Colleagues

*Gerald L. Summer, M.D.*

*Medical Director, MASA Physician Recovery Network  
(Formerly, Impaired Physician Program)*

**W**hat should you do when you are concerned about a colleague who may be involved with substance abuse including alcohol, or may be becoming impaired as a result of emotional or mental disorder? A related question is how to assist our impaired colleagues without involvement of the regulatory boards, insurance carriers, or public exposure. The answer to these questions require action to be taken.

Fear of acting prematurely, physician peer controversy, fear of reprisal or simply not doing anything allows the impairment to progress. Procrastination which may result from physician-peer conflict or fear of reprisal from licensing board or insurance carriers should not interfere with helping our colleagues. Often when symptoms and signs are suggestive of impairment in the hospital or medical office, the disease is already advanced.

The advocacy position of the Physicians Recovery Network allays these fears and allows our colleagues

who may be becoming impaired the opportunity for a confidential discrete investigation without delay. Alabama statute grants immunity for referring sources. A concerned physician or others may call without fear of his/her name being revealed. The discrete confidential investigation through the members of the Alabama Impaired Physicians Committee includes anonymity and protects the physicians professional practice.

The bottom line is that a telephone call to Physicians Recovery Network initiates the advocacy procedure for a physician. The call provides for an experienced physician to evaluate symptoms suggestive of the illness of chemical dependency, personality and psychiatric disorders. Most importantly, the physician who may be becoming impaired receives the attention he needs to prevent progression of his disease. A telephone call to 204/263-6441 or 261-2044 or 1800-239-MASA will launch on to the road of recovery.

## Call PRN For Help

If you have a dependency problem, or you are the colleague, spouse or family member of a physician who does, help is only a phone call away. And it is absolutely confidential. Call PRN (Physicians' Recovery Network) 1-800-239-MASA or 205-263-6441

On weekends, after office hours and holidays call: 1-205-514-1105.





Mrs. Stuart K. Bean  
A-MASA, President

## The Image of Doctors in the 1990s

Donna Specker, A-MASA Media Chairman 91-92

During the last year this section of "Alabama Medicine" has focused on remarkable Alabama physicians and spouses who have made a difference in their communities. While these stories may have entertained, their purpose is deeper.

Whether we read about Dr. Michael Schendal serving in the Persian Gulf war or about Dr. James Kimble building low-cost homes for Alabama families with Habitat for Humanity, we are also learning that physicians in Alabama are caring and compassionate people. With federal efforts to cut spending on health projects and the state efforts to reform workmen's compensation laws, over and over we have seen physicians and their families depicted in a very negative light. So, efforts to improve the image of our medical community are truly necessary.

Alabama has some fascinating people who happen to be doctors. You have read in this column about Dr. James Grotting and his many trips to the Philippines to correct cleft lip and cleft palate defects in Filipino children. Dr. Dick Shepard has been associated with NASA in planning space age science experiments. Dr. Michael Callahan has journeyed to India to perform and teach eye surgery. Dr. Stuart Bean has worked with the federally sponsored Disaster Medical Assistance Team to plan for national disasters. Their wives have been no less busy, whether founding and serving on the board of Habitats for Humanity, which Mrs. James Kimble has done; accompanying their spouses on medical missions to Guatemala, which Lee Stamler and Annie Bradley have done; or just trying to keep the family on a even keel, which Marilyn McVeigh has tried to do while her husband worked in Korea.

A-MASA President Jessie Bean, has used the slo-

gan, "First we gave you our heart, now we give you our support," to remind us that the spouses and families of Alabama physicians work toward a common goal. Yes, it is the physician who actually sees the patient in the office or hospital and prescribes medical care. But it is often the medical families who make such efforts possible. Wives who eat supper alone, go to see school plays, attend football games, and do homework with their children are in their own way supporting medical care in Alabama. So are the spouses who chair charitable committees, cook snacks for the annual "Healthline" phone-in, and raise money so the medical auxiliary can buy rocking chairs for a hospital nursery.

Doctors and their families do not live in a vacuum. They are, whether they like it or not, observed and critiqued daily by their neighbors, those who read about them in the newspaper and strangers in the hospital elevator. Never has a positive image of physicians and their families been more needed and more elusive.

As A-MASA heads into a new year, the state auxiliary and each county auxiliary will be trying to improve the public's impression of its local physicians. This back to basics sort of effort will hopefully help people see the Alabama physician as he or she really is: a busy person who contributes not just to his or her own family, but also to the local, national and international community of mankind.

*I would like to thank not only Donna Specker for writing and editing the stories for Alabama Medicine each month, but also those doctors, spouses, and others who volunteered their time, effort and information in the past year to make these articles possible.*

*Jessie Bean, A-MASA President 91-92*

# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

**Tired of Night Call and Administrative Burdens? Mississippi** An incredible practice is now available within a progressive, established group of Family and Industrial Medicine Physicians. No hospital call. OWNERSHIP OPPORTUNITIES in this expanding Episodic Care and Industrial Medicine Clinic system. Potential income of \$150,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Have a busy practice from day one, with extremely high, long-term income potential. Please send your CV to P.O. Box 13849, Jackson, Mississippi 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

**Tired of Working For Someone Else With No Chance For Ownership? Mississippi.** Excellent opportunities for career-oriented Emergency Physicians. OWNERSHIP OPPORTUNITIES. Local physician-owned and managed group with contracts in North, Central, and Southcentral Mississippi with potential income of \$200,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Positions available now. Please send your CV to P.O. Box 13849, Jackson, MS 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

**General Surgery Southeast;** Major water recreation area. New 40-bed hospital; excellent equipment; permanent CAT Scan. Solo practice w/coverage from surgeons affiliated with 600-bed hospital. Busy practice, over 30 procedures a month, 5-day workweek. Fee-for-service practice assures physician \$150,000 net before taxes for 2 years. Richard Glehan 800-221-4762.

**Family Practice** Would you like to practice pure medicine without the hassle of running your own business? MediCenter, Inc., is a progressive family health care provider for major corporate firms in the U.S. We are currently recruiting a fourth board-certified family physician for our clinic at the Goodyear Tire & Rubber Co. in Gadsden, Alabama. We offer salaries commensurate with experience and have one of the best benefits packages offered. If this opportunity interests you, call us collect! Ask for Paula Konneker at (405)536-4377.

**FPs and IMs desperately needed in Birmingham, Montgomery, and Tuscaloosa.** Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**FP, IM, GP needed in rural South AL flourishing practice.** Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**ER Physicians needed** for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

## SOUTHERN INDEPENDENCE

Large practice, small town. Established Family Medicine group in pre-revolutionary Pee Dee area community seeking physicians for a life-time commitment. New building, equipment, facilities, unequalled elsewhere. A truly special career opportunity in Family Medicine for a special physician. It don't get no better - friendly town with excellent quality of life. BC/BE only, please. \$100,000+. Want more info? Contact:

*Cheraw Family Medicine*

*Attention: C. Radkin*

*PO Box 867*

*Cheraw, South Carolina 29520*

*(803) 537-2171. Call collect.*





**LEONARDO  
COULD HAVE QUALIFIED  
FOR AMWA  
MEMBERSHIP.**

**CAN YOU?**

The great Renaissance man could have made it on the strength of his medical writing alone.

Or as an illustrator.

Or simply as a medical scientist.

But you can earn membership in the American Medical Writers Association — AMWA— by being any one of these. As well as by being a doctor, dentist, editor, librarian, educator, medical photographer... or by being professionally involved in medical communication.

The one inflexible criterion: you must share the conviction of AMWA's current 3,700 members that clear, concise communications is a vitally important art to be cultivated and refined.

To achieve that end, AMWA conducts workshop sessions in a variety of specialized facets of communications — including explorations into the latest electronic media. It holds local, regional, and national meetings that enable editors, physicians,

film- and video-makers, writers, publishers, illustrators, and a wide spectrum of scientific communicators to meet, talk, and exchange ideas. And it publishes a journal that exists for one purpose only... to encourage and nurture concise, lucid medical communications.

To learn more about how to join the rapidly growing ranks of AMWA members who share your concerns, write, call, or Fax the American Medical Writers Association, 9650 Rockville Pike, Bethesda Maryland 20814, (301-493-0003, Fax 301-493-0005).

Just because DaVinci missed out on AMWA membership is no reason you should!

**AMWA**  
AMERICAN  
MEDICAL WRITERS  
ASSOCIATION

# The Alabama Physicians Recovery Network (PRN)

***(Formerly Impaired Physicians Program)***

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ◆ *Intervention*
- ◆ *Education*
- ◆ *Guidence to hospital, staff and employees*
- ◆ *Recovery monitoring*
- ◆ *Structured support groups*
- ◆ *Family assistance*
- ◆ *Advocacy*
- ◆ *Liason*
- ◆ *Quality Assurance*
- ◆ *Confidentiality*

***For information call: 1-800-239-MASA or 205-263-6441***  
***On weekends, after office hours and holidays call:***  
***1-205-514-1105.***



For the many faces of mild hypertension



## THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION<sup>1\*</sup>

- Effective 24-hour control<sup>2</sup>
- Single-agent efficacy
- Well tolerated<sup>3</sup>
- No adverse effects on total cholesterol, plasma glucose levels, renal function,<sup>4</sup> or serum electrolytes<sup>5-6</sup>



For the many faces of mild hypertension

\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

† Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡ Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680



May 1992

Vol. 61, No. 11

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

## Storms On The Horizon

*page 6*

THE FRANCIS AND SOUTHERN  
LIBRARY OF MEDICINE  
BOSTON, MA

DEC 0 8 1992

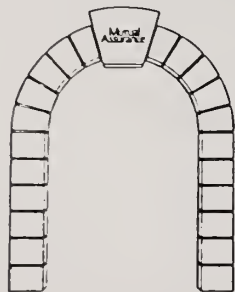


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 11, MAY 1992

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1992 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Mills, Montgomery

OFFICERS OF THE ASSOCIATION: President - Peter W. Morris, M.D. (1993)\*\*; Birmingham; President-Elect James E. West, M.D. (1993)\*\*; Anniston; Immediate Past President - William D. Lazenby, M.D. (1993)\*\*; Opelika; Vice-President - Ernest G. Moore, Jr., M.D. (1993), Birmingham; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*\*\*, Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*\*\*, Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1992 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1994 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl Grote, Jr., M.D., Huntsville. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - Peter W. Morris, M.D., Birmingham; Edgar W. Branyon, Jr., M.D., Anniston. 1994 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley.

THE STATE BOARD OF CENSORS: Richard H. Esham, M.D., Chairman (1994)\*, Mobile; William M. Lightfoot, M.D., Vice Chairman (1994)\*, 1st District, Mobile; Ellann McCrory, M.D. (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa; Joel C. Pittard, M.D., (1997), Opelika; Regina M. Benjamin, M.D., (1997)\*, 3rd District, Bayou La Batre; William A. Curry, M.D., (1997)\*, Carrollton.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

### EXECUTIVE DIRECTOR

S. Lon Connor

Secretary-Treasurer - Emmett Wyatt

### DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

ANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

Executive Director.....2  
*Pleonexia*

DEC 08 1992

President's Page.....6  
*Storms On The Horizon*

*Ninth Annual Rheumatology on the Beach*.....12  
David A. McLain, M.D., F.A.C.P., F.A.C.R.

*Panic Disorder and Pregnancy*.....16  
David E. Green, M.D.  
Deborah L. Hogan, M.D.

*Evaluating Pain Treatment Programs*.....20  
Eric C. Roberts, M.D.

*How Do You Know When Someone Is In Good Recovery?*.....28  
Gerald L. Summer, M.D.

*Practice Parameters Blues*.....29  
Ira Green, M.D.

*Auxiliary*.....30  
*Introducing Mrs. Mosley*

*Classifieds*.....31

*Newly Licensed Doctors*.....32

## Cover

The fractal beauty of moonrock, 400X, showing the stresslines of eons, may well symbolize contemporary medicine under the many discordant forces described by MASA President Peter W. Morris, M.D.: "Storms on the Horizon," page 6. (Photomicrograph from *Designs & Patterns from the Microscopic World*, copyright 1974, Lewis R. Woberg, M.D., New York, Dover Publications. reprint permission granted by the publisher.)





*S. Lon Conner*  
*Executive Director, MASA*

## Pleonexia

What do the Los Angeles riots, the HUD and S&L scandals, and the junk bond rip-offs have in common? I have no credentials as a sociologist but I think the common denominator of all of them was the same — greed.

I am no more persuaded that the torching and pilaging in Los Angeles were really about the Rodney King verdict than I am that the principals in the investment scandals thought they were really helping people, as all claimed through counsel.

The Greeks had a word for it — pleonexia — the morbid, insatiable appetite for more and more. (*Pleo*, in Greek, means simply more.) A year or so before he was convicted for securities fraud, Ivan Boesky lauded the virtues of greed to a college graduating class. He was wildly cheered by an audience of young people already infected with the pleonexia virus.

Howard Milken boasted of new financial conquests long after he had accumulated a fortune sufficient for a thousand opulent lifetimes. Nor did he have the grace to answer, as the late billionaire J. Paul Getty once did, that after a certain point in wealth accumulation, more money became only a way of keeping score. Milken wanted the world to know he was simply smarter than the pack, when in fact he was simply more larcenous.

But just as sick with the lust of materialism, and no more excusable in my reckoning, were the looting throngs who used the transparent lie of the King verdict as their excuse to seize the property and livelihood of those who had eked out only a small measure of success through the sweat of their brows. Notable among these were the hard-working Koreans and

other Asians trying to live the American dream, a dream long forgotten (if ever experienced) by the plunderers who stole their property and destroyed their businesses in a maniacal orgy of greed and envy.

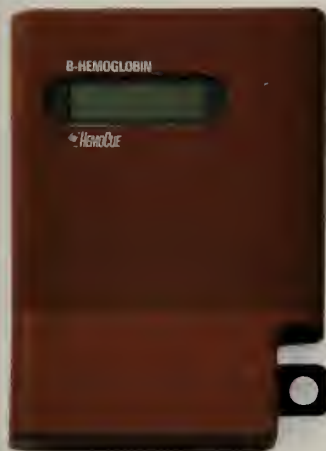
The land still echoes with the voices of their apologists, who, of course, blame it all on society for having denied them the material well-being they were forced to take for themselves. It is instructive, I think, that the riot pictures showed this effort “to reform the criminal justice system” — and we are assured by many worthy academics and other holy men that this is what it was all about — concentrated principally on the acquisition of liquor, guns, jewelry, cameras, electronics, clothing and furniture.

I blame society too but in a markedly different way. I blame society for the monstrous notion that massing of material possessions is what this country is all about. I blame society for fostering the malignant credo that a person's worth or a nation's worth can be measured only by treasure and the conspicuous flaunting thereof.

I blame society for destroying the faith of our fathers, which held that the true measure of success was what a man had accomplished to improve the human condition. If in the course of building continent-spanning railroads, constructing homes, electrifying the countryside, easing the drudgery of human toil and hardship in a thousand ways, relieving suffering and healing the sick, such benefactors accumulated substance, there were few that did not applaud their earned position.

And, more often than not in this America of my ideal, those fortunes were turned around, even long

# Lab quality results in seconds.

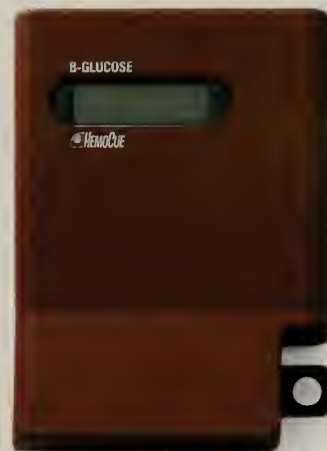


## Blood-Hemoglobin.

This portable system has revolutionized Blood-Hemoglobin testing in more than 50 countries around the world. Each year, it is used more than 35 million times – that's equivalent to one test every second

### Why?

Because, it's easy to use.  
It reduces the exposure to blood.  
It displays test results within 45 seconds.  
And most of all, it's so accurate and precise that it can be used as a diagnostic instrument.



## New! Blood-Glucose.

The newest HemoCue® system provides the benefits of the whole-blood method without the draw-backs traditionally associated with it. We believe this system will revolutionize Blood-Glucose testing.

### Why?

Because, it's easy to use.  
It reduces the exposure to blood.  
It displays test results within 40-240 seconds.  
And most of all, it's so accurate and precise that it can be used to diagnose diabetes mellitus, to screen for gestational diabetes and to measure blood glucose during oral glucose tolerance tests (OGTT).

You can try either system,  
or both, free of charge by  
calling (800) 662-7712.



Distributed by:

**AuraTech, Inc.**

3106 Solara Trace  
Greensboro, NC 27410



after the death of the benefactor, in the service of mankind.

I do not know the genesis of the greed that has swept this country. It may well be that we have been the victim of our own material success in easing the lot of our people as compared with those in other parts of the world. It may well be that we simply began to confuse shadow with substance, to worship money apart from its source — the genius of the creators and builders.

A number of years ago, shortly after Chrysler sold its military tank division, Leo Iacocca expressed dismay that investing that money in the money market made more cash by far for Chrysler than a much larger investment would in making cars. All the great corporations now maintain fleets of portfolio managers, who have become more important than the designers and fabricators, the builders. Mr. Iacocca's lament closed: "We have become a bunch of bankers, not builders."

The country needs bankers, of course; they have fueled the engines of The American Century. His point seemed to be that money is no longer seen as a legitimate and admired way of keeping score on the builders' success in advancing civilization, but as a thing apart, an idolatry detached from its roots and meanings.

The L.A. barbarians had learned well the lessons of the Age of Greed even as the Koreans they victimized had learned well the lessons of an earlier, nobler America. How do we cure this illness of the human spirit? Why, the only answer in a nation so hypnotized by the dollar is to pour more dollars on the smoldering embers.

You can judge a nation by its heroes, according to the old saying. Once we paid homage to inventors,

great writers, builders of all kinds, explorers and those who dared the unknown, humanitarians and people whose simple lives of sacrifice in behalf of their fellow humans seemed to personify the quintessential America of song and legend. Now the populace worships rock stars and other raucous, lubricious "entertainers" who are pronounced to be the greatest at something or other — not because of the intrinsic worth of their contributions but because they have grown wealthy fleecing the sheep. Wealth is the be-all and end-all of life, materialism run amok. "The Idiot Culture," it has been aptly called.

Here then is the environment of what may well be the greatest change yet in American health care. And it is the environment of pleonexia. Give us more of everything. The more it costs the better. And if you don't give us enough next year, we'll be back for more and more in the coming years. If you don't give it to us, we'll torch the inner city clinics and hospitals, thus to demonstrate the injustice of it all.

There is no denying the very real plight of many thousands of uninsured Americans, but we hear very little from them. The loudest demands come from those who simply want to be freed of the cost, at someone else's expense. I believe that major reforms are coming, but I fear the cowardly pandering and appeasement of Washington in such a time as this, when we have slipped the moorings of our national purpose, when the greedy coveting of another's goods seems to have replaced the driving force of the American Century — ambition and hard work.

Stealing from others is so much easier and quicker. Ask Messrs. Boesky and Milken; ask S&L and HUD plunderers; ask the junk bond swindlers; ask the L.A. rioters.

## Call PRN For Help

If you have a dependency problem, or you are the colleague, spouse or family member of a physician who does, help is only a phone call away. And it is absolutely confidential. Call PRN (Physicians' Recovery Network) 1-800-239-MASA or 205-263-6441

On weekends, after office hours and holidays call: 1-205-271-5759.



# Silence Is Not Golden

Is your malpractice carrier silent except when they want money? If you have questions, are you connected to someone who can answer them?

You *won't* get the silent treatment at ICA, and you *will* get answers from real people who care about you and your practice.

**Call Us,  
We'll Really Talk.**

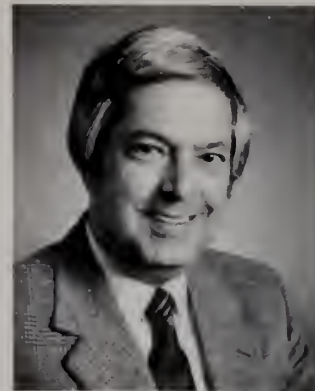
From the CEO... to the President... to an Underwriter... to a Claims Attorney... we'll talk to you about the importance of the consent-to-settle clause, our tough stand on claims, risk management, and credits to reduce your premium, anything of interest to you.



Insurance Corporation of America  
4295 San Felipe P.O. Box 56308  
Houston, Texas 77256-6308  
1-(800)-899-2356 (713) 871-8100

**Defending Defensible Doctors**





*Peter W. Morris, M.D.  
President, MASA*

## Storms On The Horizon

“In the past 12 months, the world has know changes of almost biblical proportions... The biggest thing that has happened in the world in my life, in our lives, is this: by the grace of God, America won the cold war. I mean to speak this evening of changes that can take place now that we can stop making the sacrifices we had to make when we had an avowed enemy that was a superpower. Now we can look homeward even more, and move to set right what needs to be set right....

“For the first time in 35 years, our strategic bombers stand down. No longer are they on round-the-clock alert....

“After completing 20 planes... we will shut down further production of the B-2 bomber. We will cancel the small ICBM program. We will cease production of our sea-based ballistic missiles. We will stop all new production of the Peacekeeper missile. And we will not purchase any more advanced cruise missiles....”

That was President Bush in his State of the Union Message to Congress Jan. 28. Plainly, it was in response to high public expectations that the country could now divert to domestic needs a great part of the billions that have gone for defense since World War II.

High on his list of such domestic needs was health care reform, the President said. But he offered the country half a loaf, a proposal (at this writing, not yet a bill) that would rely heavily on managed care, a threadbare concept that has done little or nothing to contain health care costs over the past decade.

Still, the prominence given health care in the State

of the Union Address was evidence enough that Mr. Bush got the message from Pennsylvania last November — when his Attorney General, Dick Thornburgh, was defeated in a race for the U.S. Senate against a political nobody, Harris Wofford. At one point, the polls had Thornburgh ahead of Wofford by a dazzling 47 percentage points.

Then Wofford came down hard and repeatedly on the need for some kind of national health plan, an issue that virtually all polls have shown to be right up there with crime as a major concern of the American people. Despite these, Mr. Bush was not seriously interested in health care reform until Mr. Thornburgh crashed in flames.

When the President did address the issue, in his State of the Union speech, he predicated the need less on the woes of the uninsured and the underinsured than on economic necessity: the rapid expansion of total national expenditures from \$800 billion this year to a predicted \$1.6 trillion by the end of this decade. Every product we buy contains this cost factor, he said, as does every product we sell in foreign markets, thus bearing on “whether or not we can compete in the world.” (Well, yes, but every product we buy or sell also contains elements of the national debt and scores of other overhead items.)

In an attempt to pre-empt other approaches, he warned also that Democratic play-or-pay bills would be exorbitantly expensive, would reduce jobs, increase taxes, introduce Americans to long lines, produce indifferent service, deny Americans the right to choose their physician and would ultimately lead to

# FREEDOM FROM PAIN!

**Extra strength pain relief  
free of extra prescribing  
restrictions.**

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

## Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

### COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS

	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

## The heritage of VICODIN<sup>®</sup>,\* over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin<sup>®</sup> ES**

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)



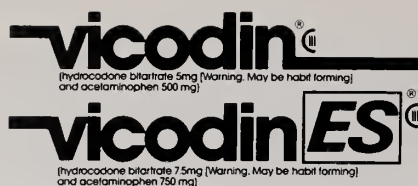
**Tablet for tablet, the most potent analgesic you can phone in.**

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knoll Pharmaceuticals

2. Standard industry new prescription audit





**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone.

**WARNINGS:**

**Respiratory Depression:** At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

**Head Injury and Increased Intracranial Pressure:** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

**PRECAUTIONS:**

**Special Risk Patients:** VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture.

**Cough Reflex:** Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease.

**Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus.

**Usage in Pregnancy:**

**Teratogenic Effects:** Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever.

**Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**ADVERSE REACTIONS:**

The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include:

**Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes.

**Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation.

**Genitourinary System:** Ureteral spasm, spasm of vesical sphincters and urinary retention have been reported.

**Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated.

**DRUG ABUSE AND DEPENDENCE:**

VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution.

**OVERDOSAGE:**

**Acetaminophen Signs and Symptoms:** In acute acetaminophen overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion.

**Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdose, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised June 1989

**Knoll Pharmaceuticals**  
A Unit of BASF K&F Corporation  
Whippany, New Jersey 07981



5864

**BASF Group**

complete government control.

While I certainly share these apprehensions, I do not believe that public demand for health care reform will be met by the President's approach. There is a tremendous groundswell out there for something far beyond what the President has in mind. I do sympathize with him, however: what the public really wants is anybody's guess. The same polls that show Americans largely satisfied with the care they are receiving also show that they want major changes — cognitive dissonance, I believe it's called.

They also want a great deal more than they are willing to pay for. No surprise there. The country has been living on the cuff so long that the very idea of actually paying for new services has become anathema to the average citizen. The end of communism in the world and the dissolution of the Soviet Union should release billions for such domestic spending, the public believes, without the need for tax increases. This fallacy might be called Gorbys's free lunch.

It is the fault of both parties, the Presidency and the Congress, that Americans don't comprehend that the \$400 billion current deficit, and the trillions, being added to daily, in the national debt, mean that we have been going in hock at a far faster rate than ever in our national history.

We haven't been paying for most of those tanks and planes but charging the bill to posterity. Thus the decision not to produce those expensive weapons results in no windfall refund, popular belief to the contrary notwithstanding.

Therefore, there is no painless way to shift defense spending to domestic spending. Additionally, when the President spoke of all those defense cutbacks in January, he was defending against deeper proposed cuts by the Democratic Congress. But a few months later that Congress has itself had a major change of heart, realizing that draconian cuts now, while still in a recession, would dump many thousands of well-paid defense workers into the already swollen unemployment lines.

No Congressman wants to face that hostility in his home district in an election year. Although maintaining defense expenditures for items we don't need is just another form of pork, it's more palatable pork. That seems to be the bipartisan agreement.

These and other factors make a major reform bill all but a non-starter this year. But concepts are being shaped and I fully expect 1993 to be Armageddon in health care. The AMA, I am happy to say, has not been asleep at the switch. It has aggressively and proactively championed a concept of universal health

# The ACCUPRIL Single-Agent Commitment<sup>TM</sup>

Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.\*†



New!  
ONCE-A-DAY ‡  
**ACCUPRIL<sup>®</sup>** <sup>TM</sup>  
quinapril HCl tablets 10, 20, 40 mg

\* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.



## Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

### INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

### CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

### WARNINGS

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

**Hypotension:** Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N=3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

**Fetal/Neonatal morbidity and mortality:** ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation during lactation, reduced offspring body weight was seen at ≥25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

### PRECAUTIONS

#### General

**Impaired renal function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

**Evaluation of hypertensive patients should always include assessment of renal function** (see DOSAGE AND ADMINISTRATION).

**Hyperkalemia and potassium-sparing diuretics:** In clinical trials, hyperkalemia (serum potassium ≥5.5 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

**Surgery/anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients

**Angioedema:** Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

**Symptomatic hypotension:** Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

**Hyperkalemia:** Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

## Accupril® (Quinapril Hydrochloride Tablets)

**Neutropenia:** Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

### Drug Interactions

**Concomitant diuretic therapy:** As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

**Agents increasing serum potassium:** Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

**Tetracycline and other drugs that interact with magnesium:** Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

**Lithium:** Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

**Other agents:** Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

### Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m<sup>2</sup> basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (50 and 10 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively).

### Pregnancy

**Pregnancy Category D:** See WARNINGS, Fetal/Neonatal morbidity and mortality.

### Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

### Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinapril compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

### Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

### ADVERSE EFFECTS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

**General:** back pain, malaise

**Cardiovascular:** palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

**Gastrointestinal:** dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

**Nervous/Psychiatric:** somnolence, vertigo, syncope, nervousness, depression

**Integumentary:** increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

**Urogenital:** acute renal failure

**Other:** amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

**Angioedema:** angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

### Clinical Laboratory Test Findings

**Hematology:** (See WARNINGS)

**Hyperkalemia:** (See PRECAUTIONS)

**Creatinine and blood urea nitrogen:** Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

\* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



PARKE-DAVIS

Division of Warner-Lambert Company

Morris Plains, New Jersey 07950

PD-103-JA-7164-A2(022)



insurance (Health Access America) that would preserve, to the maximum extent possible, the system that has long been the envy of the world.

I believe AMA is on the right track. At least this much is clear: massive resistance to change will spell massive defeat, a defeat in which the American physician would have nothing to say about whatever finally emerges as a Washington consensus. In subsequent columns, I'll examine the other proposals for health care reform.

When I was elected in April 1991, I thought my 1992-93 term would be relatively quiet. But then the same mistake was made by the Police Chief-designate for Los Angeles, who contracted with the city last year to take charge June 1 this year. I have a fair idea how he feels.

The best advice for all physicians this year and the next few years is to fasten your seatbelts until further notice. There is a lot of turbulence ahead, some that

cannot even be imagined at this time. The survivors will be those physicians who can adapt to change and who will try to influence change as it occurs. The ostrich approach is a prescription for disaster.

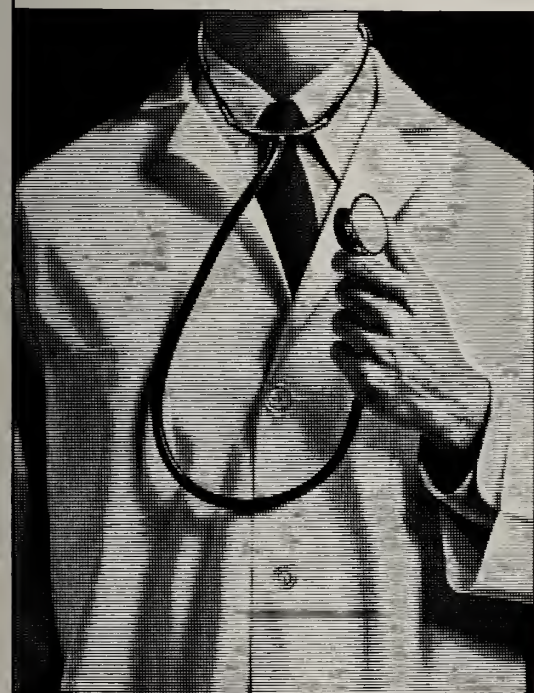
I am deeply grateful for your confidence in giving me the opportunity to serve the Association and my fellow physicians. I intend to give this stewardship my best shot, to prove worthy of your trust.

Together, I believe we can navigate our way through the storms ahead. It will not be easy and we may at times disagree on the course to take. But none of us asked for or expected certainties when we entered the profession. All of us know that the history of medicine has been marked by consensus that came only after years of controversy and often bitter disputation.

We are where we are because our predecessors never gave up.

Neither can we.

## **FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.**



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment—Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect

**ARMY HEALTH CARE TEAM**

**(404) 362-3359 or 363-5823**

**ARMY MEDICINE. BE ALL YOU CAN BE.**



# Highlights of the Ninth Annual Rheumatology on the Beach

*David A. McLain, M.D., F.A.C.P., F.A.C.R.\**

The latest research into the pathogenesis, treatment, and characterization of rheumatic diseases formed the basis for another successful Rheumatology on the Beach. The meeting, held September 12-14, 1991, at the Sandestin Resort in Destin, Florida, was sponsored by the Alabama Chapter of the Arthritis Foundation and Brookwood Medical Center and endorsed by the American College of Rheumatology. Physicians, mostly rheumatologists, from throughout the United States and this year, also from Europe, gathered to hear a stellar group of physician scientists.

## **Osteoarthritis Update**

### **Osteoarthritis Gene**

Dr. Darwin Prockop, M.D., Ph.D., Professor and Chairman of the Department of Biochemistry and Molecular Biology and Director of the Jefferson Institute of Molecular Medicine at Thomas Jefferson University in Philadelphia discussed his recently announced discovery of a gene for osteoarthritis (OA). Dr. Prockop first discussed his research into osteogenesis imperfecta (OI) and its causation by a defect in Type I collagen synthesis. Type I collagen is the type of collagen found in bone. Dr. Prockop and his collaborators discovered that one base change in DNA out of the 3 billion bases could cause OI. A number of different base changes have been identified that can cause OI and these base changes cause either "procollagen suicide" or prevent folding in the collagen causing a "kink" in the molecule which leads to dendritic fibrils. The weakening of Type I collagen by these changes in structure lead to fragile bones which fracture easily.

After his work on Type I Collagen in OI, Dr. Prockop and his colleagues turned their attention to

defects in Type II collagen biosynthesis that could lead to osteoarthritis, as type II collagen is the type found in cartilage. Type II collagen is the major source of tensile strength of cartilage. In one family studied, Dr. Prockop discovered a single base change that leads to an abnormal protein. While the normal sequence of bases in the identified mutant area is T-G-C producing the amino acid Arginine, the family members with osteoarthritis had the sequence T-G-T producing the amino acid Cystine. Additional families with osteoarthritis are being sought to further characterize base changes in type II collagen synthesis that may lead to osteoarthritis. It appears that heredity is one etiologic factor in OA, particularly in those individuals who develop it prematurely. Dr. Prockop also related that they had one patient with osteoporosis that had a mutation in type I collagen and two families with a mutation in type III collagen that had arterial aneurysms. The future of this research is to treat the abnormal gene and this provides the hope that these illnesses may be prevented in those individuals who are hereditarily predisposed. By the way, Dr. Prockop won the Arthritis Foundation (Alabama Chapter) Outstanding Speaker Award as selected by the participants.

## **Osteoarthritis Pathogenesis and Treatment Update**

Dr. Jean Pierre Pelletier, M.D., Associate Professor of Medicine, Head of the Arthritis Division, and Director, Cartilage Research Laboratory, University of Montreal, presented an update on the pathogenesis and treatment of OA. Dr. Pelletier noted that the most recent concept of OA pathophysiology states that the initial lesions occur at the cartilage level. The chondrocytes release proteolytic enzymes, mainly metalloproteases, leading to a degradation of the cartilage macromolecules (collagen, proteoglycans). The breakdown products released into the synovial fluid are phagocytosed by the synovial membrane, leading

---

\* Chief of Rheumatology, Brookwood Medical Center, Birmingham, Alabama

to an inflammatory reaction. Synovial inflammation increases the synthesis of local proteolytic enzymes by the infiltrating macrophages, synoviocytes, and synovial lining cells. This in turn leads to local tissue destruction and possibly, to cartilage degradation as the enzymes diffuse into the cartilage matrix. Interleukin-1 (IL-1) and possibly other cytokines synthesized by synoviocytes and macrophages increase the synthesis of synovial and cartilage metalloproteases, thus leading to further cartilage degradation and creating a vicious cycle. It is believed that once metalloproteases have been synthesized in a latent form, a physiological activator, such as plasminogen activator/plasmin working in a cascade-like system, play a major role in this degradation. Another important OA phenomenon that occurs at the same time as the degradative process is the repair process, as chondrocytes synthesize new proteoglycan and collagen molecules in an attempt to repair the lesions in the cartilage matrix. It is believed that OA lesions appear and progress when the catabolic process overcomes the anabolic process.

Dr. Pelletier next reviewed the treatment of OA in the context of the above scheme of pathogenesis. Specifically he reviewed the evidence for the treatment of OA using nonsteroidal antiinflammatory drugs (NSAID) and intraarticular corticosteroid injections. Dr. Pelletier noted that NSAIDs and intraarticular steroid injections are often extremely helpful in relieving the symptoms of millions of patients with OA. To date, no studies have been done to demonstrate whether drugs that relieve OA symptoms also induce remission of the disease. Controversy exists concerning the use of intraarticular corticosteroid injections. However, recent work in spontaneous and experimental animal models indicates that some NSAID and corticosteroids may reduce the progression of OA lesions. Dr. Pelletier next reviewed the studies on the effects of NSAIDs on normal and OA cartilage metabolism. Studies indicate that certain NSAIDs decrease plasminogen activator concentrations and inhibit IL-1 receptors. This indicates that NSAIDs may have a "remittive" as well as analgesic role in OA.

Dr. Pelletier concluded with a discussion of the therapeutic effectiveness of intraarticular corticosteroid injections. Dr. Pelletier noted that while the efficacy of intraarticular steroid injections in relieving OA symptoms has been well established, many physicians are reluctant to use steroid injections because they fear potential deleterious effects on cartilage. Their assumptions come from studies indicating that corticosteroid injections may suppress cartilage pro-

teoglycan synthesis and that oral or intraarticular corticosteroids may worsen OA cartilage lesions in animal models or even cause degenerative lesions in normal cartilage. However, careful analysis of these studies, which were conducted using experimental conditions, were found to not have much clinical relevance. Studies done under more realistic experimental conditions, using drug doses in a close usual therapeutic range, have given a more optimistic view on the use of intraarticular corticosteroids for treatment of OA. Dr. Pelletier next reviewed studies indicating that in animal models using these usual therapeutic doses of corticosteroids there was a reduced incidence and severity of cartilage lesions and osteophytes. These findings are not surprising since steroids can suppress metalloprotease synthesis and can also suppress synthesis of possible physiological activators of metalloproteases such as plasminogen activators and cytokines, such as IL-1. Dr. Pelletier concluded his discussion by noting that at therapeutic doses, steroid injections are unlikely to damage articular cartilage and recent data is optimistic about their therapeutic effectiveness. It is not known whether NSAIDs and corticosteroids have the capacity to modify the natural course of cartilage degradation in humans. However, if used judiciously, they are extremely useful in the treatment of OA.

### **A Wider Spectrum of Spondyloarthropathies**

Dr. Muhammad Khan, M.D., Professor of Medicine at Case Western Reserve University and Director of Rheumatology at MetroHealth Medical Center in Cleveland and noted spondyloarthropathy expert expanded the horizon on HLA B27 positive spondyloarthropathies in his talk on "A wider spectrum of spondyloarthropathies (SpA)". Dr. Khan noted that seronegative spondyloarthropathy is a heterogeneous clinical entity that includes ankylosing spondylitis, reactive arthritis (including Reiter's syndrome), psoriatic arthritis, and the arthritis associated with inflammatory bowel diseases. Dr. Khan noted that the current classification may be too narrow to encompass all the subsets of SpA patients. There is a need to broaden the criteria to encompass all SpA patients that do not fit into the present classification. He noted that in the early stages of SpA, classification is often the most difficult. The characteristic signs and symptoms for subgroups may only become manifest after prolonged follow-up and after examination of the patient's family members. Also, current diagnostic criteria also include radiographic evidence of sacroiliitis. Dr. Khan noted that this may be too restricted because there are

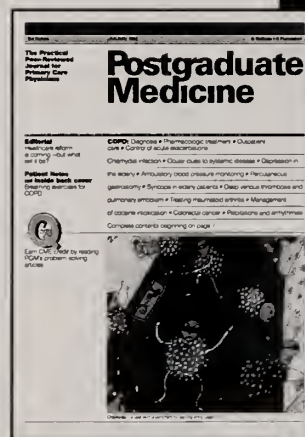


patients with sacroiliac and axial skeletal involvement who do not have erosive sacroiliac disease on x-ray. Studying families with spondylitic disease and HLA B27 positivity, members are identified who have inflammatory back pain, thoracic pain and stiffness, and sternocostal or costochondral junction pain and tenderness without radiographic sacroiliitis. Dr. Khan cited a study by Mau (J. Rheumatol. 15:1109-1114, 1988) where 88 patients with "possible AS" were followed for 10 years. They had chronic low back pain with at least one of the following features: peripheral arthritis, heel pain, anterior uveitis, or raised ESR. At the end of 10 years, 60% had definite AS and another 20% had undifferentiated SpA. This study indicates that not all patients with ankylosing spondylitis have radiologic evidence of sacroiliitis when they first consult a physician for their back pain.

Dr. Khan then reviewed various HLA B27 associated inflammatory diseases that have been recognized worldwide. These include the cardiac syndrome of "lone aortic incompetence and pacemaker-requiring bradycardia"; incomplete Reiter's syndrome or "B27-associated reactive arthritis" that has been reported following enteric or urogenital infections (and recently *Borrelia burgdorferi* and HIV); and "undifferentiated" clinical syndromes including seronegative oligoarthritis, polyarthritis, or dactylitis ("sausage-like" toes) of the lower extremities, and heel pain caused by calcaneal (and tarsal) periostitis. HLA-B27-associated lower limb oligoarthropathy, without evidence of any preceding enteric or urogenital infection or any clinical evidence of inflammatory bowel disease or psoriasis, is often associated with Achilles tendonitis and calcaneal periostitis. It is not unusual to find other family members with ankylosing spondylitis, reactive arthritis, or acute anterior uveitis.

Dr. Khan concluded his talk with a discussion of the European Spondyloarthropathy Study Group (ESSG) preliminary criteria for classification of spondyloarthropathy. These criteria include inflammatory spinal pain or synovitis which is asymmetrical and predominantly in the lower limbs with any one of the following: positive family history, psoriasis, inflammatory bowel disease, alternate buttock pain, or enthesopathy. Using these criteria gave a sensitivity of 77% and a specificity of 89%. Adding sacroiliitis increased sensitivity to 86% with a specificity of 87%. Dr. Khan expressed the hope that future epidemiologic studies of spondyloarthropathy will use these newly developed ESSG preliminary classification criteria and this will broaden our understanding of spondyloarthropathies and their manifestations.

## US THEM



**Postgraduate  
Medicine**

**WHEN YOU NEED  
TIME ON YOUR  
SIDE, THE CHOICE  
IS CLEAR.**

**NO CLINICAL  
CLUTTER—  
PGM ARTICLES  
ARE CLEAR,  
CONCISE, WELL  
ILLUSTRATED,  
AND PRACTICAL.**

# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM**

## **\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**



# Panic Disorder and Pregnancy

*David E. Green, M.D.\**  
*Deborah L. Hogan, M.D.†*

## Introduction

Panic disorder is defined as recurrent panic attacks occurring at unpredictable times not associated with marked physical exertion or a life-threatening situation. The attacks are characterized by onset of intense apprehension, fear or terror associated with feelings of impending doom. Physical symptoms include dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, dizziness, vertigo or unsteady feelings, feelings of unreality, paresthesia, hot and cold flashes, sweating, faintness, trembling or shaking, and a fear of dying, going crazy, or doing something uncontrolled during the attack. The attacks are usually short-lived, but on rare occasions, may last for hours. Panic disorders usually begin in late adolescence or early to mid-adult life and may be limited to a single brief period lasting several weeks or months or may recur several times or become chronic. This disorder is rarely incapacitating except when very severe and complicated by agoraphobia.<sup>1</sup>

Panic attack is more common in women and must be differentiated from other conditions such as hypoglycemia, pheochromocytoma, and hyperthyroidism—all of which may cause similar symptoms. Likewise, withdrawal from substance abuse such as barbiturates or the use of intoxicating substances such as caffeine or amphetamines may result in panic-like attacks.<sup>1</sup>

Previous reports indicate that pregnancy alleviates many of the symptoms of panic disorder.<sup>2</sup> It has also been reported that panic disorders arise in the postpartum period and may be confused with postpartum depression.<sup>3</sup> There is an isolated

report of abruptio placenta occurring with a panic attack during pregnancy.<sup>4</sup> The following case discussion represents the first report of a panic disorder arising during pregnancy and occurring at no other time.

## Case Report

A 35-year-old white woman—gravida 5, para 3, aborta 1—was seen for her first prenatal visit in the eighth week of pregnancy. She described her last pregnancy as complicated by acute shortness of breath, her heart running away, sweating, trembling, overwhelming feelings of doom, and feelings of being out of control. She described these episodes as beginning around the 12th week of her pregnancy and increasing in severity and frequency until six weeks following delivery. She complained of these symptoms during prior pregnancies; however, she was told, "You have to live with it." She voiced grave concern this pregnancy would result in the same type of feelings. The patient reported a history of alcoholism in both mother and father, and she specifically denied having panic attacks at any other time.

At her first visit, the patient's social history included a second marriage of approximately 2 months and her unemployment. The initial physical examination was unremarkable. Laboratory studies disclosed the following values: hematocrit, 38.1%; hemoglobin, 13.3 g/dL; blood type, A positive; RPR, nonreactive; rubella, not immune; antibody screen, negative; and pap smear, negative. Gonorrhea, chlamydia, group B strep, and hepatitis screens were all negative. Because of the patient's age, she was offered genetic amniocentesis and accepted.

On her second visit at approximately 12 weeks, a size-to-dates discrepancy was noted and an ultrasound confirmed a twin gestation. The patient voiced initial disbelief and apprehension at this information but stated she was otherwise doing well. She was referred for genetic amniocentesis at 16 weeks, but on arrival at the referral center, she began to feel "panicky." A

---

\*Assistant Professor, Department of Obstetrics and Gynecology; 201 Governors Drive, SW, Huntsville, Alabama 35801, (205) 551-4480.

†Assistant Professor, Department of Psychiatry; School of Primary Medical Care, The University of Alabama in Huntsville, Huntsville, Alabama.

level 2 ultrasound and genetic counseling were performed; however, the patient refused to undergo genetic amniocentesis.

She returned at 18 weeks and described the onset of dyspnea, palpitations, feelings of unreality, sweating, trembling, and feeling totally out of control. She denied these episodes were brought about by any specific activity and described them as lasting for what seemed "like an eternity," when in reality they only lasted for several minutes. The patient stated that nothing alleviated these symptoms, and they would disappear as rapidly as they developed. A thyroid function screen performed at this visit disclosed the following values: thyroid-stimulating hormone, 3.5 uU/mL (normal .59-4.78 uU/mL); triiodothyronine ( $T_3$ ) uptake, 20% (normal 25-37%); thyroxine ( $T_4$ ), 12.4 ug/mL (normal 4.5-12.5 ug/mL); and a  $T_3:T_4$  index of 2.0 (normal 1.1-4.6). Her O'Sullivan was 125 mg/dL. She denied any use of caffeine or other medications and had no explanation for onset of these attacks. Psychiatric consultation was suggested, but the patient declined.

The patient returned at 20 weeks gestation

disheveled, tearful and very anxious. She stated the attacks had increased in severity and frequency over the previous two weeks and were now interfering with her ability to sleep. She also reported that her husband was not supportive. With encouragement, the patient accepted psychiatric consultation, and the diagnosis of panic disorder was confirmed at the initial interview. She was given imipramine 25 mg. at bedtime, and the dosage was gradually increased to 100 mg. at bedtime. Her total imipramine/desipramine level was 245 mg/L (therapeutic 150-300 mg/L). She began psychotherapy, and her husband began to accompany her on obstetric visits. She reported an improvement in her panic attacks within the first few days of therapy.

The patient's twin pregnancy was managed with serial ultrasounds, and discordant growth was diagnosed late in the second trimester. At 32 weeks, she began weekly non-stress tests and daily fetal movement counts for both fetuses. She presented at 35 1/2 weeks in labor and delivered vaginally without complication. Twin A was a 2268 g boy with Apgar scores of 8/9 at 1 and 5 minutes. Twin B was a 1568 g girl with Apgar scores of 8/9 at 1 and 5 minutes and had a cleft

# Emergency Medicine Opportunity

■ ■ ■  
*Phenix City, Alabama*

Located in Southeast Alabama across the river from Columbus, Georgia. Annual ED volume of 13,500 in this 300-bed hospital.

**SPECTRUM<sup>®</sup>**  
**EMERGENCY CARE**

A member of The ARA Group

P.O. Box 419052, St. Louis, MO 63141

## *The Spectrum Advantages*

- Very competitive fees.
- High-limit occurrence-based malpractice insurance.
- Flexible schedules.

For details call  
**Joyce Solomon or  
Carmine Iannotti at  
1-800-325-3982**



palate. The newborns were observed in the special care nursery, required no ventilatory assistance, and were discharged from the hospital without problems.

The patient had no complication after delivery and she was instructed to continue taking imipramine through six weeks postpartum while nursing her infants. She was weaned from the imipramine and reported no further panic attacks. However, she remains in psychotherapy and is currently being treated for intrusive thoughts with Prozac. The infants were doing well at six weeks postpartum.

Laboratory value of imipramine/desipramine in maternal serum immediately prior to delivery was 55/139 mg/L, and cord blood levels of imipramine/desipramine were <25/54 mg/L in both Twin A and Twin B. A drug screen performed on the newborns at 12 hours postpartum was positive for imipramine.

## Discussion

Reports of panic disorder in pregnancy are scarce although the disorder is described as common with a predilection to women of reproductive age.<sup>1</sup> George et al. described three cases of women with panic disorders who subsequently became pregnant. In all three patients, the frequency of panic attacks decreased during pregnancy so that each patient was medication-free by the third trimester and experiencing no panic attacks. Following delivery, each patient had reoccurrence of their panic disorder symptoms. It was hypothesized by Dr. George that many underlying mechanisms of pregnancy might improve panic disorder through increases of metabolic rate, ventilatory capacity with a decrease in partial pressure of CO<sub>2</sub>, and hormonal changes that interact with barbiturate receptors producing barbiturate-like activity.<sup>2</sup>

Dr. Cohen et al. described abruptio placenta associated with a panic attack in an untreated patient. He suggested that the potentially detrimental effects of panic attacks during pregnancy must be weighed when considering whether pharmacotherapeutic intervention is appropriate.<sup>4</sup> The greatest number of articles discussing panic attacks and pregnancy deals with postpartum panic disorders described by Dr. Metz, et al. These cases occur only in the postpartum period and must be distinguished from the more common postpartum depression disorder. Dr. Metz reported successful treatment with medication and counselling in all cases.<sup>3,5-8</sup>

A recent neuroanatomical hypothesis for panic disorder described by Drs. Gorman et al. suggests that panic disorder may occur at three different levels in

the central nervous system. Brain stem function mediated through the vagus nerve is responsible for peripheral anatomic organ functions resulting in rapid breathing, rapid heart rate, and sweating. The mid-brain with its corticoreticular pathway and limbic system is involved with anxiety and feelings of impending doom, while the prefrontal cortex is associated with phobic avoidance (agoraphobia). This all-inclusive hypothesis accounts for clinically observed phenomena of increased anxiety attacks in clinical studies with hypercarbia and sodium lactate administration. It also takes into consideration the effects of behavioral techniques on decreasing the occurrence of panic attacks with phobic disorder as well as accounting for the successful therapy with imipramine in treating panic disorder. Specifically, effective treatment with behavioral techniques focuses on input from the prefrontal cortex or learned behavior areas, while the pharmacotherapeutic approach with imipramine reduces the central noradrenergic turnover and the firing rate in the locus ceruleus. Dr. Gorman's theory reinforces the observation that benzodiazepine therapy has little effect on an acute panic attack in normal doses but does successfully blunt the anticipatory anxiety associated with panic disorder by acting on the limbic system.<sup>9</sup>

This case report differs from those previously seen in the literature in that the patient's panic attacks occur only when she is pregnant. In attempting to explain the apparent discrepancy between patients presented by Dr. George and the patient presented in this report, it is useful to consider each of the three levels described by Gorman. As the metabolic rate changes throughout pregnancy, the irritable locus in the brain stem brought on by metabolic perfusion mismatch may be brought into balance resulting in a decrease in panic attacks as described by Dr. George.<sup>2</sup> In this patient, a normal functioning brain stem may become imbalanced as a result of these same metabolic rate changes. Hypercarbia has been shown to increase panic attacks in people suffering with panic disorder, and pregnancy is known to induce a hypocarbic state secondary to increased ventilatory capacity.<sup>2,10</sup> There is an increased awareness of a desire to breathe, common even in early pregnancy, and this may be interpreted by the patient as dyspnea which may provoke anticipatory anxiety through a *perceived* mismatch in perfusion and metabolic rate.<sup>11</sup>

Anticipatory anxiety mediated through the limbic system in the midbrain may be altered by pregnancy. Dr. George suggests certain steroid derivatives including progesterone metabolites possess barbiturate-like

activity and may be anxiolytic.<sup>2</sup> On the other hand, patients who develop preeclampsia during pregnancy have an increased sensitivity to norepinephrine and angiotensin II.<sup>12</sup> Such a hypersensitive state could mediate an anxiety attack in the same way as a person normally responds to a life-threatening situation.

On the cognitive level, pregnancy may have a calming or anxiety provoking effect based on past experiences. With the patients presented by Dr. George, one could speculate that any effect which decreased the frequency of panic attacks would be perceived as favorable by the patient, thus lowering the anxiety provoking stimulus input from the cortex to the limbic system. On the other hand, as with this patient, pregnancy itself may become the phobia based on prior experience.

While it cannot be argued that pregnancy may serve to alleviate many of the symptoms of panic disorder in some patients, pregnancy may also serve to initiate or provoke panic disorder in others as illustrated with this patient. This apparent discrepancy is not inconsistent with the current neuroanatomic hypothesis of panic disorder.

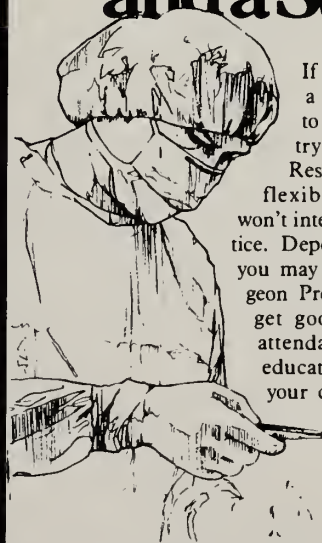
The consideration of pharmacotherapy for the patient in this report was made weighing the risk of her illness and its potential effect on twin pregnancy with the potential risk of imipramine on the fetuses. Both tricyclic antidepressants and benzodiazepines have been used successfully during pregnancy. There are no data to suggest that the rare organ dysgenesis seen with first trimester exposure of tricyclic antidepressants in animals may also occur in humans. Because there are no prospective studies with tricyclic antidepressants in pregnancy, the safety of this drug cannot be fully asserted.<sup>13</sup> Cleft palate, seen in this case, is unlikely a result of medication since imipramine was begun in the middle of the second trimester. Small amounts of imipramine may cross the milk barrier; however, the American Academy of Pediatrics considers imipramine use in mothers compatible with breastfeeding.<sup>14</sup>

The absence of reports of panic disorder occurring during pregnancy may be attributed to pregnancy's positive effect on panic disorder. This disorder may also remain unrecognized in a busy obstetric practice. Whereas 1-2% of the general population is affected with panic disorder and the symptoms may be easily controlled during pregnancy, a wider recognition of panic disorder in the obstetric community will result in more frequent diagnosis and proper management. Close consultation with psychiatry is recommended for joint treatment of this disorder during pregnancy.

## BIBLIOGRAPHY

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 3rd ed. Washington, DC: American Psychiatric Association; 1987:139-143.
2. George DT, Ladenheim JA, Nutt DJ. Effect of pregnancy on panic attacks. *Am J Psychiatry*. 1987;144:1078-1079.
3. Metz A, Sichel DA, Goff DC. Postpartum panic disorder. *J Clin Psychiatry*. 1988;49:278-279.
4. Cohen LS, Rosenbaum JF, Heller VL. Panic attack associated placental abruption: A case report. *J Clin Psychiatry*. 1989;50:266-267.
5. Kraus RP. Letters to the editor. *J Clin Psychiatry*. 1989;50:268.
6. Bybee P. Letters to the editor. *J Clin Psychiatry*. 1989;50:268. Fisch RZ. Letters to the editor. *J Clin Psychiatry*. 1989;50:268-269.
8. Metz A, Sichel DA, Goff DC. Letters to the editor. *J Clin Psychiatry*. 1989;50:269.
9. Gorman JM, Liebowitz MR, Fryer AJ, et al. A neuroanatomical hypothesis for panic disorder. *Am J Psychiatry*. 1989;146:148-159.
10. Pritchard JA, MacDonald PC, Gant NF. *Williams Obstetrics*. 17th ed. Norwalk, Ct: Appleton-Century-Crofts; 1985:191.
11. Milne JS, Howie AD, Pack AI. Dyspnoea during normal pregnancy. *Br J Obstet Gynaecol*. 1978;85:260.
12. Pritchard JA, MacDonald PC, Gant NF. *Williams Obstetrics*. 17th ed. Norwalk, Ct: Appleton-Century-Crofts; 1985: 529.
13. Cohen LS, Heller VL, Rosenbaum JF. Treatment guidelines for psychotropic drug use in pregnancy. *Psychosomatics*. 1989;30:25-33.
14. Briggs GG, Freeman RK, Yaffe SJ. *Drugs in Pregnancy and Lactation*. 2nd ed. Baltimore, Md: Williams and Wilkins; 1986:218-219.

## An Officer and a Surgeon



If you're a surgeon looking for a change of pace and a chance to sharpen your surgical skills, try your hand in the Air Force Reserve. Serve part-time. Our flexible participation schedule won't interfere with your private practice. Depending on your experience, you may qualify for the Flight Surgeon Program. As an officer, you'll get good pay, benefits and paid attendance to continuing medical education (CME) activities. Serve your country. Serve yourself. For more information, call (404)421-4892. Today's Air Force Reserve...it's a great way to serve.

**AIR FORCE RESERVE**

14-214-0004

**A GREAT WAY TO SERVE**



# Evaluating Pain Treatment Programs: A Literature Review

*Eric C. Roberts, M.D.\**

"Pain has an element of blank; It cannot recollect when it began, or if there were a day when it was not."

—Emily Dickinson

## **Abstract**

The impetus for this project is an attempt to describe by comparison and literature review a pain control program that would provide active patient participation in a highly structured, intense, objectively graded program of comprehensive functional restoration that meets governmental, medical, moral, and ethical standards. Brena indicates that "... there are too many facilities which claim to be pain clinics ... bewildering physicians about their choice for referring their patients."

## **Economics**

Traditionally, pain has always been considered a symptom of a disease, with the basic approach being to identify the cause of the pain and remove or correct it. This point of view is useful in cases of acute injury, but its validity in chronic pain has been challenged over the last 20 years by a large body of basic and clinical research. Complaints of chronic pain are probably the most common feature of patients seeking medical advice. The American Academy of Orthopedic Surgeons reports that each year there are 36 million office visits to physicians in the United States for back pain alone, and nearly 20 million hospital days with an average length of stay of about nine days.<sup>2</sup> The cost of compensating pain sufferers in 1981 was estimated to be \$20 billion. Including the

cost of lost productivity, the figure rises to \$50 billion.<sup>3</sup>

## **Pain Perception**

Because pain perception is based upon cognitive set or expectancy and the individual's emotional state, as well as negatively reinforcing escape mechanisms (e.g., the secondary relief or gain provided a soldier allowed the combat zone due to a wound) in the "pain environment," these factors can all significantly effect the experience of pain.<sup>4</sup> The pain problem is most likely due to what is termed a "pain-go-round," fueled and propelled by the aforementioned pain perception. The pain-go-round is a circular repetitive process of pain treatment and disappointment, followed by new treatment, new hope, renewed pain, and more disappointment.<sup>5</sup>

## **Traditional Viewpoints and Expectations**

Although the duration and details of pain management vary with each patient, the general approach is the same. All patients are actively involved in an interdisciplinary treatment program primarily emphasizing a nonsurgical functional restoration and physical medicine approach.<sup>6</sup> These treatment programs are man's effort to alleviate what the International Association for the Study of Pain (1979) calls "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. In the realm of low back pain alone, the annual cost is currently estimated to exceed \$20 billion dollars per year, and is considered to be the most expensive health care problem in the 20 to 50 age group.

The total compensation for LBP is estimated to be \$4.6 billion dollars, and the cost per case is now more than \$6,000 and climbing.<sup>7</sup>

These specialized treatment programs and pain centers now operating have lofty expectations

---

\*Montgomery Rehabilitation Hospital, 4465 Narrow Lane Road, Montgomery, Alabama 36116

ascribed by both health care worker and layman. They are to:

... help in preventing pain states from growing into a "pain illness," will reduce human suffering, will diminish medical expenditure, will contribute to a better cooperation between basic scientists and clinicians, will help to disseminate new information on pain mechanisms and diagnostic and treatment modalities, and will lead to a better understanding of the complex problem of ... pain.<sup>8</sup>

We expect a pain program to evaluate, treat, guide, and rehabilitate patients suffering from pain. Expectations are to evaluate and treat those acute and subacute pain states which do not respond to therapeutic modalities by other physicians. Furthermore, pain programs are to counsel colleagues by telephone or writing, train physicians and other health care professionals of the pain unit as well as physicians in training, pain therapists, and private physicians. Finally, the pain program is to "bear expert witness for chronic pain patients."<sup>9</sup> Other expectations include the organization and maintenance of postgraduate meetings on pain for all health professionals, perform interdisciplinary pain studies, and carry out basic research.

### **Pain States and Controversy**

Clearly, many pain states exist. Loesen and Fordyce have described thalamic syndrome, tic douloureux, postherpetic neuralgia, post thoracotomy pain, nerve root avulsion syndromes, phantom limb pain, atypical facial pain, arachnoiditis, causalgia, and neuralgias as causes.<sup>10</sup> Wall and Melzack, in their *Textbook of Pain*, point out that the Central Nervous System functions not as a simple telephone system, but as an extremely complex computer capable of modulating, processing, and storing large loads of sensory information leading to a painful perception which may have little linear relationship with any given peripheral stimulation. The ethicist/author C. S. Lewis, although describing spiritual and moral struggles in his book, *The Problem of Pain*, perhaps unwittingly entitles our current effort to ameliorate an unpleasant sensory and emotional experience associated with actual or potential tissue damage.

There are also diverse opinions and conflicting findings that further muddy the water of pain control. Kosterlitz and Terenius maintain that even well-staffed and organized pain treatment centers are no panacea, achieving only limited satisfactory long-term results. While some researchers and clinicians

have advocated rest in their treatment regimens, Tollison flatly states that there is no inherent relationship between pain and non-healing, and ... that ... rest and physical inactivity may inhibit healing.<sup>11</sup> It is commonly held that radicular pain associated with certain varieties of back pain is due to nerve compression, but Rosomoff emphatically writes that compression of the nerve produces not pain, but paresthesia, and that the pain of disk herniation is not neural compression but myofascial.<sup>12</sup> Hendler defines pain relief obstacles in terms of problems related to prior psychiatric history, pending litigation, and preexisting pain of greater than one year.<sup>13</sup>

### **Acute Versus Chronic Pain**

Of particular importance is the concept of acute versus chronic pain. One school of thought views acute and chronic pain as existing on a continuum and distinguished only by the passage of time. A second school views acute and chronic pain as distinct, albeit related, physiological and psychological entities.<sup>14</sup> A review of the literature reveals a scarcity of research comparing the efficacy of treatments of patient population suffering acute and chronic pain.<sup>15</sup> Furthermore, there also appears to be little research data addressing the utility of comprehensive restorative treatment of individuals suffering pain of recent onset.<sup>16</sup>

Typical descriptions of acute pain include association with a distinct cause, fairly well-defined course, and termination after healing occurs. Chronic pain is commonly thought to be reverberatory or other self-sustaining neural process that results in pain memory, last more than six months, prove more resistant to treatment, and have persistent tension after healing has taken place.<sup>17</sup>

Until recently, chronic pain as a malfunction was not recognized as a diagnostic entity, separated from acute pain as a symptom. According to Brena, there are few validated systems for assessment of chronic pain states which include quantification of medical, psychosocial, and behavioral factors. Consequently, Brena writes that a chronic pain patient who fails to respond to traditional medical intervention is usually viewed as mentally ill.<sup>18</sup>

### **The Chronic Pain Syndrome**

Congress mandated the Secretary of Health and Human Services to appoint a commission on the evaluation of pain and to make recommendations on how pain should be considered in the evaluation of pain-disabled patients. A study performed by the Office of Disability of the SSA found that in patients meeting



diagnostic criteria for a Chronic Pain Syndrome (CPS), musculoskeletal malfunctions were significantly involved more than any other disease entity:

1. Musculoskeletal disorders 56.7%
2. Cardiovascular diseases 16.6%
3. Neoplastic diseases 17.6%
4. Mental disorders 4.1%

Six common Chronic Pain Syndrome factors were elucidated:

1. Intractable pain of six months or more
2. Marked alteration of behavior with depression and anxiety
3. Marked restrictions in daily activities
4. Excessive use of drugs and frequent use of medical services
5. No clear relationship to organic disorders
6. History of multiple non-productive tests, treatments, and surgeries

A taxonomy of Chronic Pain Syndrome patients was included in the Commission's report.

Group A—inability to cope, insufficient documented medical impairment by lack of significant medical findings (this group presents with most of the CPS symptoms, which are not "... psychogenic, unreal, or imaginary. . .")

Group B—competent coping, insufficient documented medical impairment by lack of significant medical findings.

Group C—inability to cope, documented impairment by positive medical findings.

Group D—competent coping, document impairment by positive medical findings.<sup>19</sup>

CPS is not a psychiatric diagnosis, although emotional and psychological factors are important components.

The Commission concludes that it is presently possible to establish protocols for evaluation of individuals complaining of chronic pain, leading to an acceptable diagnosis and a management program. Management should be mainly focused toward rehabilitation; it must be multimodal and time-restricted to be cost effective.<sup>20</sup>

### Quality Pain Treatment Program Evaluation

The Commission on Accreditation of Rehabilitation Facilities (CARF) has recognized quality pain programs, with standards established since 1983. The CARF report of March of 1987 recognized

84 certified programs. In 1987, a document for program evaluation in chronic pain program was devised.<sup>21</sup>

Perez, in his presentation at the 20th annual review course in Physical Medicine and Rehabilitation, stated that a systems approach to the management and evaluation of chronic pain is essential to maximize rehabilitation efforts. He added that the delineation of clearly defined objectives and the steps necessary to reach these objectives play a major part in reassuring the patient that the system is working for him, and not against him. Roles of the effective pain management system include reinforcing the patient's role in his own treatment, early identification of program inadequacies, a legal system that reinforces just and prompt settlement of financial and legal issues, emphasis on reintegration into work force, insurance industry that fosters development of pain prevention programs, a family system that is willing to work on the issues of pain as communication as well as become a well-behaviors facilitator, and a willing employer ready to hire back the injured worker even if it means adjusting to the worker's abilities.<sup>22</sup>

### Pain Program Types

According to Kosterlitz and Terenius, there are four types of pain centers. The major comprehensive and comprehensive pain centers differ, in that the comprehensive center does not have its own inpatient beds, nor its own space. They both have full-time professional and supportive staff, patient record review prior to admission, preadmission patient screening, psychological assessment, consultation by related specialties; teaching, training, and research programs; therapeutic modalities, and patient follow-up. Syndrome oriented pain centers offer thorough evaluation and treatment of particular pain syndromes (arthritis centers, causalgia and RSD centers, etc.). Some programs may operate for the management of specific pain syndromes, or organizations may operate programs such as industrial injury clinics, sports injury clinics, etc. Finally, the modality oriented pain center may utilize mono- or multidisciplinary patient work-up schemes, applying certain limited treatment modalities (nerve blocks, psychotherapy, TENS, etc.). However, modality oriented pain centers may or may not provide extensive evaluative procedures.<sup>23</sup> The effectiveness of each type of pain center will depend on the selection of its mono- or multi-disciplinary staff, its pain evaluative procedures, and its therapeutic modalities.

Grabois maintains that from his analysis of 251

treatment programs from the Pain Clinic Directory, many are unifocal and undisciplinary.<sup>24</sup> His analyses include:

1. Anesthesiology oriented 61%
2. Neurology/Neurosurgery 11%
3. Phys Medicine and Rehab 4%
4. Orthopedics 4%
5. Psychiatry 7%
6. Dental 3%
7. Internal Medicine 1%

#### Affiliation:

1. Private Hospital 44%
2. Teaching Institution 30.2%
3. Veterans Hospital 5.9%
4. Private Clinic 15.9%
5. Other 3-4%

### The Pain Specialists

The physician providing medical direction of the pain program should possess training and/or experience in the management of persons with pain, as well

as meet Category One and Two prerequisites, according to the 1988 Standards Manual for Organizations Serving People with Disabilities by the Commission on Accreditation of Rehabilitation Facilities. The Pain Clinic Group can include: general practitioner, anesthesiologist, internist, neurologist, physiatrist, orthopedist, psychiatrist, resident physician, visiting physician, psychologist, medical sociologist, pain trainee, social worker, secretary, physical therapist, occupational therapist, and nurse.<sup>25</sup>

With regards to the medical staff, non-physicians should not be selected (especially if the program wishes to have CARF accreditation) as they lack medical knowledge for a complete differential diagnosis; cannot legally accept medical responsibility; they also tend to be narrow in their view of patient problems and diagnoses.<sup>26</sup>

### Pain Program Organization

The screening procedure follows patient referral in the scheme of the pain program organization. The prospective patient is to fill in a detailed pain questionnaire. He will undergo psychometric testing, and will keep a daily record of his activities with regards to pain and medication. A compilation of pre-existent



## SPECIALIZE IN AIR FORCE MEDICINE.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. Find out how to qualify. Call

**USAF HEALTH PROFESSIONS  
TOLL FREE  
1-800-423-USAF**







NEW INDICATION

## ONLY ONE H<sub>2</sub>-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H<sub>2</sub>-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.<sup>1</sup>

**AXID**<sup>®</sup>  
nizatidine  

---

150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

# AXID<sup>®</sup>

## nizatidine capsules

**Brief Summary. Consult the package insert for complete prescribing information.**

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests:** False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions:** No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

[101591]

Additional information available to the profession on request.



Eli Lilly and Company  
Indianapolis, Indiana  
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY

medical records will ensue, including hospitalizations and names and addresses of hospitals and physicians who previously rendered treatment. It is estimated that the time necessary for the first appointment for screening should require one hour for the physician, one and one half hours for the secretary. The detailed work-up should be completed in two to three days. A standardized screening procedure avoids missing key areas of the patient's history and physical, and saves time and money.

A review of the screening by the staff ensues, and a preliminary diagnosis is rendered. After the first interview, appropriate consultations are ordered. The pain clinic conference, a regularly held two-hour meeting, next takes place. The diagnosis is again considered, and a polymodal, multidimensional treatment plan goes into full swing. Review of program efficacy is an ongoing process through the pain clinic conference, as noted above. After discharge from the timerestricted program, a maintenance program becomes the next step, emphasizing patient responsibility. The patient continues with weekly group therapy sessions, and keeps a journal of drug use, sleep activities, and weight which can be reviewed by the physician. Helping family, relatives, and friends to understand their roles in the behavior of a chronic pain patient is critical, since returning a patient to an environment that has reinforced secondary gains will undermine all gains in improved activity level a patient might have experienced.

## Diagnostic and Treatment Modalities

Minimal diagnostic procedures utilized by a pain clinic may include EMG/NCV, thermography, fluoroscopy, x-ray, doppler flow, EMG biofeedback, Bender-Gestalt, WAIS, memory quotient, Halsted-Reitan battery, Hendler Screening Test for Chronic Pain, and SCL-90.

Methods of treatment described encompass TENS, EMG with thermal feedback, occupational therapy, narcotic drug withdrawal, selection of proper psychotropic agent, family and couple and sexual counseling, weight loss, behavior modification, psychotherapy, acupuncture, relaxation techniques, anatomy and physiology education, vocational counseling, education regarding rationale behind exercise program, pharmacology of pain medications, stress management, sleep improvement, depression avoidance, increasing interpersonal communication skills, and physical therapy classes that deal with body mechanics, aerobic exercise, and stretching, since exercise is known to reduce stress, facilitate sleep, and has proven more effective than single dose



meprobamate in reducing muscular tension long associated with the "pain-muscular tension" in association with pain.<sup>27</sup>

## Conclusion

An effective pain program consists of active, as opposed to passive, physical therapy; physical strengthening; increasing stamina and endurance; nerve block evaluation and physical medicine modalities; instruction in body mechanics and relaxation training; medication treatments; behavior modification; and both individual and group psychotherapy; work hardening; and a variety of educational classes. Active patient participation in a highly structured, intense, objectively graded program of comprehensive functional restoration is required.<sup>28</sup>

## Footnotes

1 Brena, SF. The chronic pain syndrome: A new medical diagnosis. *Issues in Pain*. 1988; 1(2).

2 Id.

3 Perez, FI. Managing pain as a behavior. Presentation at 20th Anniversary Review Course in Physical Medicine and Rehabilitation, Baylor College of Medicine, Houston, Texas, April 1986.

4 Fordyce, WE, Steger, JC. Chronic pain. *Behavioral Medicine: Therapy and Practice*. Williams and Wilkins, 1979, 125-129.

5 Id.

6 Tollison, CD, Kriegel, ML, et al. Comprehensive treatment of acute and chronic low back pain: A clinical outcome comparison. *Orthopedic Review*. Vol. 18, No. 1. Jan. 1989. 59-64.

7 Pope, MH. Concepts in the prevention of occupational low back pain. *Contemporary Orthopedics*. 1988 September 17(3); 43-54.

8 Pain and society. eds. HW Rosterlitz and LV Terenius. 403-414. Dahlem Konferenzen 1981. Weinheim: Verlag Chemie Bmbh.

9 Id.

10 Loeser, JD, Fordyce, WE. Chronic pain. *Behavioral Medicine: Therapy and Practice*. Williams and Wilkins, New York, 1979.

11 Tollison, CD, Kriegel, ML, et al. Comprehensive treatment of acute and chronic low back pain: A clinical outcome comparison. *Orthopedic Review*. Vol. 18, No. 1. Jan. 1989. 59-64.

12 Id.

13 Hendler, N. Diagnosis and nonsurgical management of chronic pain. Raven Press, New York 1981; 173-186.

14 Tollison, CD, Rriegel, ML, et al. Comprehensive treatment of acute and chronic low back pain: A clinical outcome comparison. *Orthopedic Review*. Vol. 18, No. 1. Jan. 1989. 59-64.

15 Brena, SF. The chronic pain syndrome: A new medical diagnosis. *Issues in Pain*. 1988; 1(2).

16 Brena, SF, Chapman, SL. Chronic pain: An algorithm for management. *Postgraduate Medicine*. July 1982. 72(1);111-117.

17 Grabis, M. Pain clinics: Role in the rehabilitation of patients with chronic pain. *Annals of the Academy of Medicine*. Singapore, 12(3):428-433, July 1983.

18 Brena, SF. The chronic pain syndrome: A new medical diagnosis. *Issues in Pain*. 1988; 1(2).

19 Id.

20 Report of the Social Security Commission on the Evaluation of Pain. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

21 Brena, SF, Chapman, SL. Chronic pain: An algorithm for management. *Postgraduate Medicine*. July 1982. 72(1);111-117.

22 Perez, FI. Managing pain as a behavior. Presentation at 20th Anniversary Review Course in Physical Medicine and Rehabilitation, Baylor College of Medicine, Houston, Texas, April 1986.

# Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992

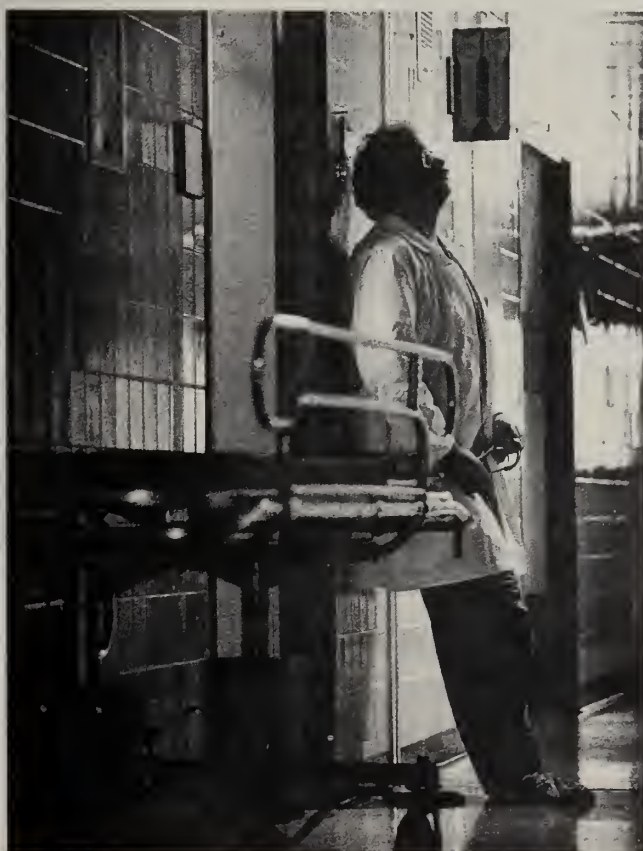
Above rates are provided by Jackson National Life

- 23 Pain and society. eds. HW Rosterlitz and LV Terenius. 403-414. Dahlem Konferenzen 1981. Weinheim: Verlag Chemie Bmbh.
- 24 Grabois, M. Pain clinics: Role in the rehabilitation of patients with chronic pain. *Annals of the Academy of Medicine*. Singapore, 12(3):428-433, July 1983.
- 25 Pain and society. eds. HW Kosterlitz and LV Terenius. 403-414. Dahlem Konferenzen 1981. Weinheim: Verlag Chemie Bmbh.
- 26 Hendler, N. Diagnosis and nonsurgical management of chronic pain. Raven Press, New York 1981; 173-186.
- 27 Tollison, CD, Kriegel, ML, et al. Comprehensive treatment of acute and chronic low back pain: A clinical outcome comparison. *Orthopedic Review*. Vol. 18, No. 1. Jan. 1989. 59-64.
- 28 Id.

## References

- Andersson, GBJ. Epidemiologic aspect on low-back pain in industry. *Spine*. 6(1):53-60, Jan/Feb 1981.
- Aronoff, GM, Evans, WO. The prediction of treatment outcome at a multidisciplinary pain center. *Pain*. 14 (1982) 67-73.
- Basbaum, AI, Fields, HL. Endogenous pain control systems: Brainstem spinal pathways and endorphin circuitry. *Ann. Rev. Neurosci.* 7:309-38, 1984.
- Berger, AR, Schaumburg, HH. Rehabilitation of peripheral neuropathies. *J. Neuro. Rehab.* 1988; 2:25-36.
- Berger, AR, Schaumburg, HH. Rehabilitation of focal nerve injuries. *J. Neuro. Rehab.* 1988; 2:65-91.
- Blacker, H.M. Biofeedback. From the Pain Control and Biofeedback Clinic, Baylor College of Medicine, 21st Comprehensive Review Course in Physical Medicine and Rehabilitation, Houston, Texas, March 1987.
- Brena, SF. The chronic pain syndrome: A new medical diagnosis. *Issues in Pain*. 1988; 1(2).
- Brena, SF, Chapman, SL. Chronic pain: An algorithm for management. *Postgraduate Medicine*. July 1982. 72(1); 111-117.
- Carron, H. Nerve blocks for pain management. *Advances in Pain Research and Therapy*. Vol. 6; 1984.
- Dixon, GW. The current status of the scientific basis for manipulation. *Curr. Concepts Rehabil. Med.* Vol. 2, January 1985.
- Fields, HL. Pain II: New approaches to management. *Annals of Neurology* 9(2); Feb. 1981; 101-106.
- Foley, RM. The treatment of cancer pain. *NEJM*. Vol. 313 No. 2, July 1983; 84-95.
- Goodman, CE. Low back pain in the cosmetic athlete. *The Physician and Sportsmedicine*. Aug 87. 15(8); 97-102.
- Grabois, M. Pain clinics: Role in the rehabilitation of patients with chronic pain.

- Annals of the Academy of Medicine*. Singapore, 12(3):428-433, July 1983.
- Fordyce, WE, Steger, JC. Chronic pain. *Behavioral Medicine: Therapy and Practice*. Williams and Wilkins, 1979, 125-129.
- Hendler, N. Diagnosis and nonsurgical management of chronic pain. Raven Press, New York 1981; 173-186.
- Keim, HA, Kirkaldy-Willis WH. Low back pain. *Clinical Symposia*. CIBA. 32(6), 1980.
- Kotke, FJ. Evaluation and treatment of low back pain due to mechanical causes. *Archives PM & R*. 1961 June; 426-440.
- LaBan, MM, Wesolowski, DP. Night pain associated with diminished cardiopulmonary compliance: A concomitant of lumbar spinal stenosis and degenerative spondylolisthesis. *Am. Journal of PM & R*. Aug. 1988 67(4); 155-160.
- Lacouture, PG, Gaudreault, P, et al. Chronic pain of childhood: a pharmacologic approach. *Pediatric Clinics of North America*. Vol. 31, No. 5; 1984. 1133-1151.
- Levy, MH. Pain management in advanced cancer. *Seminars in Oncology*. Vol. 12(4), December 1985; 394-410.
- Looser, JD, Fordyce, WE. Chronic pain. *Behavioral Medicine: Therapy and Practice*. Williams and Wilkins, New York, 1979.
- Pain and society. eds. HW Kosterlitz and LV Terenius. 403-414. Dahlem Konferenzen 1981. Weinheim: Verlag Chemie Bmbh.
- Perez, FI. Managing pain as a behavior. Presentation at 20th Anniversary Review Course in Physical Medicine and Rehabilitation, Baylor College of Medicine, Houston, Texas, April 1986.
- Pope, MH. Concepts in the prevention of occupational low back pain. *Contemporary Orthopedics*. 1988 September 17(3); 43-54.
- Report of the Social Security Commission on the Evaluation of Pain. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.
- Salzberg, C, Hanley, D, et al. Back school - a valuable rehabilitation tool for the management of low back pain. *Pain Management*. March/April 1988. 17(2); 78-84.
- Standards Manual for Organizations Serving People. Commission on Accreditation of Rehabilitation Facilities. 1988. 2500 N. Pantano Rd., Tucson, AZ 85715.
- Thorsteinsson, G. Electrical stimulation for analgesia. *Therapeutic Electricity and Ultraviolet Radiation*. G.R. Stillwell (ed). Williams and Wilkins (Baltimore/London), 1983. 113.
- Tollison, CD, Kriegel, ML, et al. Comprehensive treatment of acute and chronic low back pain: A clinical outcome comparison. *Orthopedic Review*. Vol. 18, No. 1. Jan. 1989. 59-64.
- Warden, S, Auvenshine, D. Chronic pain: assessment and management. University of Kentucky College of Nursing, 1986.
- White, RH. The patient with aches and pains. *Postgraduate Medicine*. 1987 (April). 81(5); 216-226.



## "Being a patient advocate is what being a physician is all about."

Dr. Kevin Fullin, Cardiologist, Kenosha, Wisconsin,  
Member, American Medical Association

Why would a cardiologist get involved in the issue of family violence? Perhaps, because what he saw simply cried out for action.

"Fully a third of all women's injuries coming into our emergency rooms are no accident," says Dr. Fullin.

While others were content to downplay the issue of family violence, Dr. Fullin would not. He petitioned state officials, and through his efforts the first Domestic Violence Advocate Program in his state was created.

"Organized medicine must serve as an advocate for patients," stressed Dr. Fullin.

The American Medical Association (AMA) couldn't agree more. We're committed to focusing physician attention on the issue of family violence.

Become a member of the AMA today.

Members of the AMA are encouraged to join their state, county and specialty societies.

**American Medical Association**

Physicians dedicated to the health of America





# How Do You Know When Someone Is In Good Recovery?

Gerald L. Summer, M.D.

*Medical Director, MASA Physician Recovery Network (PRN)  
(Formerly, Impaired Physician Program)*

The American Medical Association estimates 10 to 15% of physicians will become impaired at some time in their professional career secondary to substance abuse, including alcohol, mental or emotional disorders. Most of these diseases are treatable. The Alabama Impaired Physicians Committee addresses these illnesses through the Physicians Recovery Network (PRN), the Impaired Physicians Program of MASA. The primary goal of PRN is advocacy for the sick physician. To return the sick physician to a functioning, productive individual in his professional relationships and personal family benefits all of society.

To achieve this goal, a confidential aftercare monitoring contract is developed tailored specifically to the needs of the individual physician. The PRN contract developed after consideration of the experience of several other state contracts, is continued for five years and is subject to renewal. The contract calls for three types of physician involvement in the participants care plan. The first physician is a monitoring physician. The monitoring physician is aware of the participants specific illness and is available for consultation, urine drug monitoring if necessary, and letters of advocacy concerning his overall functioning status.

The second type of physician is a supervision physician. Ideally that individual is of the same specialty as the participants and is aware of the participants medical practice sufficiently that he is capable of writing letters of advocacy on a quarterly basis or more often if necessary. The third type of physician is a personal physician. The recovering physician is discouraged from self-diagnosis of any illness, and self-treatment with any mood-altering drugs, especially benzodiazepines. Self-treatment in recovering physicians may predispose to relapse into the primary drug of choice. The personal physician produces letters of advocacy for the physician upon request of PRN.

The participant is required to attend aftercare meetings in the form of Caduceus meetings and other recovery group meetings such as Alcoholics Anonymous or Narcotics Anonymous. If sexual

behavior has been an issue in his acute illness, then he is directed toward a recovery group of individuals who have had similar difficulties. The Caduceus group is composed of other professionals with similar interest such as nurses, dentists, physicians, pharmacists, and psychologists who are capable of sharing their experience, strength and hope on a professional level in which the participant is comfortable. Individual psychotherapy may be indicated, tailored to the specific needs of the recovering physician. The participant is encouraged to avoid all mood-altering chemicals unless specifically prescribed by a physician who has the approval of the Alabama Impaired Physicians Committee.

Through encouragement of these monitoring mechanisms in the advocacy contract, there gradually occurs over a period of time a genuine disposal of denial. This change in attitude develops over a period of months or years. As honest willingness develops, physician participants attend recovery group meetings not because they are required to, but because they want to. Through personal one on one contact with the physician listed in the recovery contract and the Medical Director of PRN, it becomes evident that the recovering physician begins to assume personal responsibility for his/her personal recovery. When this mature attitude becomes apparent, accelerated recovery begins and sobriety assumes its priority as a way of life for the individual. Family involvement in the recovery process is extremely important. The advocacy contract addresses this issue. Family participation is encouraged during the initial treatment process and continued in aftercare recovery program. As a result, the entire family actively participates and relationships are positively strengthened as a unit.

True recovery becomes evident when the recovering physician expresses a desire to become involved. Recovering physicians reach out to help each other by their example. Their colleagues become more confident in the recovery process, and the goal of the PRN becomes more readily achievable.



## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association





Mrs. B. R. Mosley  
A-MASA, President

## Introducing Mrs. Mosley

*Introduction by Mrs. Michael Huddle, president of the Mobile County Medical Auxiliary on April 10 at the installation of Mrs. B. R. Mosley as president of the auxiliary to the Medical Association of the State of Alabama: Mrs. Mosley is a former high school teacher of business education and English and has been married for thirty-four years to B. R. Mosley, a Mobile urologist. She is the mother of two adult children and became the grandmother of Katherine Parker Glass on March 26. Mrs. Mosley served as Mobile County president in 1980-81 and has served on the state board since that time. She is vitally interested in public education, devoted to historic preservation and involved in the processes of her chosen political party. She is an active member of the Spring Hill Baptist Church.*

*Mrs. Mosley stated that two life-changing events for her were being a director of Camp Rap-A-Hope, a childrens' oncology camp operated by the Mobile Auxiliary, and tutoring in the Chickasaw School Partners in Education program. She states that a person cannot be involved in projects of this kind and be the same person they were before.*

You will see that the logo for this year is a triangle intertwined with a caduceus with the words "In Giving We Grow." I would like to thank a friend and Mobile auxilian, Stacy Howell, for this logo. The base of the triangle represents Maslow's Theory of Basic Motivation:

Our basic needs. When these, which are, food, air, water, clothing and physical safety and security, are

met, we can move on to meet the needs of others.

Our basic physical needs have all been met, and we can now move on to meet other social needs.

Those who have been given a great deal are required to give a great deal, and in so doing in meet our needs for self-fulfillment, selfexpression and self-actualization.

In Florence Littauer's book, *It Takes so Little to be Above Average*, she tells the story of a group, of which she was a member, that was selecting officers. The nominating chairman stood up and said, "We didn't have time to meet so I thought it would be fun if we went around the room and each one of you say why you can't be on next year's board. The one with the worst excuse gets the job."

That is not the way you were chosen. You were asked to service, thoughtfully, carefully, lovingly, because you could be:

Women who are examples for others to follow

Women who are willing to take a change

Women who will encourage others

Women who aren't touchy or petty

Women who can think beyond the moment

Women who have the attitude and bearing of a leaderwomen who try to look their best

Women who can call a meeting to order

Women who will open their homes

Women who have compassion for those in need

Women who are ready to pursue excellence

Don't be willing to accept mediocrity. The mantle of leadership has fallen on you. Wear it well.

# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

**General Surgery** Southeast; Major water recreation area. New 40-bed hospital; excellent equipment; permanent CAT Scan. Solo practice w/coverage from surgeons affiliated with 600-bed hospital. Busy practice, over 30 procedures a month, 5-day workweek. Fee-for-service practice assures physician \$150,000 net before taxes for 2 years. Richard Glehan 800-221-4762.

**Family Practice** Would you like to practice pure medicine without the hassle of running your own business? MediCenter, Inc., is a progressive family health care provider for major corporate firms in the U.S. We are currently recruiting a fourth board-certified family physician for our clinic at the Goodyear Tire & Rubber Co. in Gadsden, Alabama. We offer salaries commensurate with experience and have one of the best benefits packages offered. If this opportunity interests you, call us collect! Ask for Paula Konneker at (405)536-4377.

**FPs and IMs desperately needed in Birmingham, Montgomery, and Tuscaloosa.** Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**FP, IM, GP needed in rural South AL flourishing practice.** Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**ER Physicians needed** for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**Tired of Night Call and Administrative Burdens? Mississippi** An incredible practice is now available within a progressive, established group of Family and Industrial Medicine Physicians. No hospital call. OWNERSHIP OPPORTUNITIES in this expanding Episodic Care and Industrial Medicine Clinic system. Potential income of

\$150,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Have a busy practice from day one, with extremely high, long-term income potential. Please send your CV to P.O. Box 13849, Jackson, Mississippi 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

**Tired of Working For Someone Else With No Chance For Ownership? Mississippi.** Excellent opportunities for career-oriented Emergency Physicians. OWNERSHIP OPPORTUNITIES. Local physician-owned and managed group with contracts in North, Central, and Southcentral Mississippi with potential income of \$200,000+ including guarantee PLUS fee for service. Package includes Malpractice, Health, Life, Disability, CME, Dues, and Profit Sharing Plan contributions, in addition to Holiday and Vacation pay. Positions available now. Please send your CV to P.O. Box 13849, Jackson, MS 39236-3849 or contact Sheila M. Harkins at 1-800-844-6503 to arrange an interview.

## Internal Medicine Physician

We are currently seeking a general internal medicine physician to join a well-established practice in association with a 365 bed, not-for-profit hospital in the Southeast. The hospital has annual revenues of approximately \$133 million. Candidate will be a board-certified or board-eligible internist.

Attractive salary and benefits package is offered (including immediate vesting in the pension plan, money purchase and profit sharing plan.) Contact Mr. John J. Baumann, Vice President of J. J. & H., Ltd. at (404)952-3877.



# Newly Licensed Doctors

Venable, Robert Stephen, M.D.  
Medical Center East  
Emergency Dept. Administration  
50 Medical Park East Drive  
Birmingham, AL 35235

Dosunmu-Ogunbi, Sesi Olufunmilayo, M.D.  
1504 Springhill Avenue  
Department Pediatrics  
Mobile, AL 36640-0130

McGee, Lawrence Stone, M.D.  
1125 Oakdale Road  
Department Internal Medicine  
Augusta, GA 30904

Williams, David Wayne, M.D.  
P. O. Drawer 6987  
Dothan, AL 36302

Keller, Jay Shannon, M.D.  
1216 Somerville Road, SE  
Department Ob-Gyn  
Decatur, AL 35601

Tippitt, Daniel Dale, D.O.  
329 Glendale Avenue  
Department Anesthesiology  
Atlanta, GA 30307

Perron, Ghislain, M.D.  
620 Principale  
Department Family Practice  
St. Adelphe, Quebec, Canada GOX 2G0

Statkus, Joseph Kevin, M.D.  
2602 Rose Valley Court  
Department Anesthesiology  
Fort Washington, MD 20744

Ata, Muhammad Ejaz, M.D.  
Jackson County Hospital/  
Nursing Home  
P. O. Box 1050 Woods Cove Road  
Scotsboro, AL 35768

Chen, Harold, M.D.  
Department of Medical Genetics

Room 214, CC/CB  
Mobile, AL 36688

Halpin, Dermot Patrick, M.D.  
Baptist Medical Center Montclair/  
Med. Education  
800 Montclair Road  
Birmingham, AL 35213

Hart, Eileen Marie, M.D.  
UAB/Department Nuclear Medicine  
619 19th Street South  
Birmingham, AL 35235

Abt, John Louis, D.O.  
Department Emergency Medicine  
50 Medical Park East Drive  
Birmingham, AL 35235

Batts, Kenneth Brandon, D.O.  
Chief, Family Practice Clinic  
Walson Army Hospital  
Ft. Dix, NJ 08640

Bell, Maria Caroline, M.D.  
UAB/Department Ob-Gyn, 550 OHB  
618 South 20th Street  
Birmingham, AL 35233

Berneburg, Kurt James, D.O.  
Lyster Army Hospital  
Department Hyperbaric Medicine  
Ft. Rucker, AL 36362

Blankenship, Danny Clayton, M.D.  
Birmingham Cardiovascular Group  
2022 Brookwood Medical Center Dr.,  
Ste. 303ACC  
Birmingham, AL 35209

Bone, Samuel Nicholas, 111, M.D.  
14824 Bothell Way, NE, Apt. 262  
Seattle, WA 98155

Connolly, Michael George, Jr., M.D.  
Birmingham Cardiovascular Group  
2022 Brookwood Medical Center Dr.,

Ste. 304ACC  
Birmingham, AL 35209

Dressel, Marshall Van Campen, M.D.  
721 West Market Street, Suite B  
Department Pediatrics  
Athens, AL 35611

Faircloth, William Brenton, M.D.  
Neurosurgery P. A.  
P. O. Box 850129  
Mobile, AL 36685

Gross, Steven Robert, M.D.  
Anesthesia Associates, P.A.  
P. O. Box 8305  
Gadsden, AL 35902

Hardison, Cary Don, M.D.  
130 Crabapple Way  
Emergency Medicine  
Alpharetta, GA 30201

Kleinman, Jeffrey L., M.D.  
925 Franklin Street, Suite D  
Department Anesthesiology  
Huntsville, AL 35801

Leski, Mark James, M.D.  
1239 Chaplin Drive  
Family Practice/Sports Medicine  
Columbus, GA 31904

Melchionna, Kenneth Victor, M.D.  
117 Betz Avenue  
Department Ophthalmology  
New Orleans, LA 70121

Powers, George Charles, M.D.  
5622 Evers Road, #1006  
Department Pediatric Medicine  
San Antonio, TX 78238

Proffitt, Randy Douglas, M.D.  
1720 Springhill Avenue, Suite 305  
Department Plastic Surgery  
Mobile, AL 36604

# YOCON<sup>®</sup>

## YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

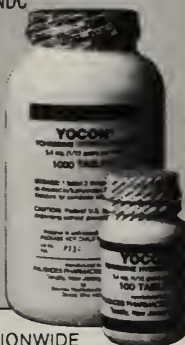
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES  
PHARMACEUTICALS, INC.**

219 County Road  
Tenaflly, New Jersey 07670  
(201) 569-8502  
1-800-237-9083

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be type-written, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.



Syklawer, Ricardo, M.D.  
Radiology Associates of Dothan  
1900 Fairview Avenue  
Dothan, AL 36301

Tucker, Mark Reid, M.D.  
Eye Associates, P.C., Suite 201  
1506 Highway 280 By-Pass  
Alexander City, AL 35010

Van Allen, Michael Ross, M.D.  
11520 SW 45th  
Department Orthopaedic Surgery  
Portland, OR 97219

Weathers, Malcolm Houston, III, M.D.  
Radiology Group, P.A.  
1216 13th Avenue, SE  
Decatur, AL 35602

Wyble, Stephen Scott, M.D.  
Anesthesia Services, P.C.  
201 Cox Street  
Mobile, AL 36604

Guice, John M., M.D.  
Anniston Urologic Associates  
411 East 9th Street  
Anniston, AL 36201

Rampulla, Elliot John, M.D.  
USAMC/Department Anesthesiology  
2451 Fillingim Street  
Mobile, AL 36617

McDermott, Timothy Joseph, M.D.  
112 East Haven Drive, Suite C  
Department Cardiology  
Dothan, AL 36301

Perkins, David Ervin, M.D.  
Anesthesia Consultants Medical  
Group, PC  
P. O. Box 1546

Dothan, AL 36302

Hook, Kathryn Elizabeth Hyde, M.D.  
908 South 20th Street, Suite 214  
Department Ob-Gyn  
Birmingham, AL 35294

Nace, Gary Stephen, M.D.  
1628 South Observatory Drive  
Nashville, TN 37215  
After 6/10/92:  
Medical Arts Center, Building #21  
121 North 20th Street  
Opelika, AL 36801

Patino, Jose Manuel, M.D.  
Childsberg Medical Surgical Center  
Department Family Medicine  
P. O. Box 369  
Childsberg, AL 35044

Ball, Stuart Furtwangler, M.D.  
LSU Eye Center  
2020 Gravier Street, Suite B  
New Orleans, LA 70112  
After 7/01/92:  
Mobile Eye Center, P. C .  
2880 Dauphin Street  
Mobile, AL 36606

Browning, Douglas Guy, M.D.  
Hughston Sports Medicine Foundation  
6262 Hamilton Road  
Columbus, GA 31955-3199

Davison, Thomas Hooks, M.D.  
115 Manning Drive, Suite A-202  
Neonatology/Pediatrics  
Huntsville, AL 35804

Stalnaker, Todd Daniel, D.O.  
5001 Grande Drive, #422  
Pensacola, FL 32504

Warner, Kathleen Joan, M.D.  
1125 East 56th Street  
Department Internal Medicine  
Indianapolis, IN 46220

Goncalves, Mark Andre, M.D.  
Cardiovascular/Thoracic Surgery  
3 Mobile Infirmary Circle, Ste. 302  
Mobile, AL 36607

Aaland, Mary Oline, M.D.  
4301 West Markham, Slot 520  
Department General Surgery  
Little Rock, AR 72205

Dotson, Randy Gene, M.D.  
110 North Lafayette  
Pulmonary Critical Care  
Mobile, AL 36604

Kennedy, Karla Grow, M.D.  
Women's Medical Plaza, Suite 412  
2006 Brookwood Medical Center Dr.  
Birmingham, AL 35209

Reischel, Ulrich Andress, M.D.  
2320 Erin Lane  
Nashville, TN 37221

Urban, Donald Avera, M.D.  
3636 Taliluna Avenue, Apt. 125  
Urology Division  
Knoxville, TN 37919

Sherrer, William Todd, M.D.  
PSC 556 Box 584  
Flight Surgeon /General Medicine  
FPO AP 96372-0584

Chadalavada, Ramesh, M.D.  
12200 Vonn Road, #6B  
Pulmonary & Internal Medicine  
Largo, FL 34644

# The Alabama Physicians Recovery Network (PRN)

***(Formerly Impaired Physicians Program)***

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ◆ *Intervention*
- ◆ *Education*
- ◆ *Guidence to hospital, staff and employees*
- ◆ *Recovery monitoring*
- ◆ *Structured support groups*
- ◆ *Family assistance*
- ◆ *Advocacy*
- ◆ *Liason*
- ◆ *Quality Assurance*
- ◆ *Confidentiality*

***For information call: 1-800-239-MASA or 205-263-6441***  
***On weekends, after office hours and holidays call:***  
***1-205-271-5759***



For the many faces of mild hypertension



## THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION<sup>1\*</sup>

- Effective 24-hour control<sup>2</sup>
- Single-agent efficacy
- Well tolerated<sup>3</sup>
- No adverse effects on total cholesterol, plasma glucose levels, renal function,<sup>4</sup> or serum electrolytes<sup>3-6</sup>



For the many faces of mild hypertension

\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

† Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡ Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:  
G.D. Searle & Co.  
Medical & Scientific  
Information Department  
4901 Searle Parkway  
Skokie, IL 60077

**SEARLE**

G.D. Searle & Co.  
Box 5110, Chicago, IL 60680

June 1992

Vol. 61, No. 12

# Alabama Medicine

JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

## The Good Old Days Are NOW

pg. 8

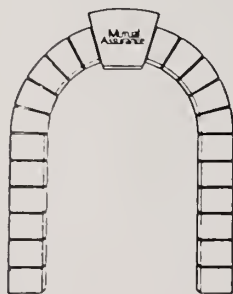


**RARELY ARE THERE EASY  
ANSWERS,**



**BUT THERE ARE INTELLIGENT  
CHOICES.**

The Keystone  
of Your Protection



**Mutual  
Assurance**

100 Brookwood Place  
Birmingham, AL 35209  
205-877-4400  
1-800-272-6401

# Alabama Medicine

Journal of the Medical Association of the State of Alabama

VOL. 61, NO. 12, JUNE 1992

(USPS 284720)  
ISSN 0738-4947

OFFICE OF PUBLICATION: P.O. Box 1900, Montgomery Alabama 36102-1900. Subscription Prices: member, \$15.00, non-member, \$30.00 per year \$2.50 per copy. Second class postage paid at Montgomery, Alabama and at additional offices. Published monthly by The Medical Association of The State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to Alabama Medicine, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for The Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1992 by the Medical Association  
of the State of Alabama

## EDITOR

Claude L. Brown, Jr., M.D., Mobile

## ASSISTANT EDITOR

Wm. H. McDonald, Montgomery

## ADVERTISING & DESIGN

Rhonda Mills, Montgomery

OFFICERS OF THE ASSOCIATION: President - Peter W. Morris, M.D. (1993)\*, Birmingham; President-Elect James E. West, M.D. (1993)\*, Anniston; Immediate Past President - William D. Lazenby, M.D. (1993)\*, Opelika; Vice-President - Ernest G. Moore, Jr., M.D. (1993), Birmingham; Speaker, House of Delegates - Richard O. Russell, Jr., M.D. (1994)\*, Birmingham; Vice-Speaker, House of Delegates - R. Bob Mullins, M.D. (1994)\*, Valley.

DELEGATES AND ALTERNATES AMERICAN MEDICAL ASSOCIATION (Terms expiring December 31 of year shown) 1992 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl A. Grote, Jr., M.D., Huntsville. 1993 Delegates - Jon E. Sanford, M.D., Fayette; Kenneth C. Yohn, M.D., Eufaula. 1994 Delegates - Julius Michaelson, M.D., Foley; William T. Wright, M.D., Mobile; Carl Grote, Jr., M.D., Huntsville. 1992 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley. 1993 Alternates - Peter W. Morris, M.D., Birmingham; Edgar W. Branyon, Jr., M.D., Anniston. 1994 Alternates - Burt F. Taylor, M.D., Mobile; Garland C. Hall, Jr., M.D., Moulton; R. Bob Mullins, Jr., M.D., Valley.

THE STATE BOARD OF CENSORS: Richard H. Esham, M.D., Chairman (1994)\*, Mobile; William M. Lightfoot, M.D., Vice Chairman (1994)\*, 1st District, Mobile; Ellann McCrory, M.D. (1993), 4th District, Ft. Payne; Garland C. Hall, Jr., M.D. (1993), 5th District, Moulton; Patrick B. Jones, Jr., M.D. (1994), 2nd District, Dothan; Jon E. Sanford, M.D. (1994)\*, Fayette; Pink L. Folmar, M.D., (1996), 6th District, Birmingham; Robert H. Story, M.D., (1996)\*, Tuskegee; James H. Walburn, M.D., (1996), 7th District, Tuscaloosa; Joel C. Pittard, M.D., (1997), Opelika; Regina M. Benjamin, M.D., (1997)\*, 3rd District, Bayou La Batre; William A. Curry, M.D., (1997)\*, Carrollton.

\*At large

\*\*Member, Board of Censors

\*\*\*Ex-Officio Member, Board of Censors

STATE HEALTH OFFICER: Claude Earl Fox, M.D., Montgomery.

## - STAFF -

## EXECUTIVE DIRECTOR

S. Lon Conner

Secretary-Treasurer - Emmett Wyatt

## DEPARTMENTS

Legal - Wendell R. Morgan

Education - George D. Oetting

Governmental Affairs - Richard C. Whitaker

Public Relations - Holley Midgley

Communications - Wm. H. McDonald

## In This Issue

*Addiction - A Family Affliction*.....2  
Mary Lou Hanks, D.D.

Executive Director.....4  
*Happiness and the Radical Middle*

President's Page.....8  
*The Good Old Days Are Now*

*Alcohol: Yesterday and Today*.....13  
Sean Allison and Thomas W. Sheehy, M.D.

*Fluidotherapy*.....20  
Richard T. Herrick, M.D., F.A.C.S.

*The Crisis of Rising Health Care Cost*.....26  
Steven Stokes, M.D.

Auxiliary.....32  
*Inside-Out*

Classifieds.....33

Newly Licensed Doctors.....34



# Addiction - A Family Affliction

*Mary Lou Hanks, D.D.\**

The purpose of a healthy family is to nurture each person's growth as an individual. To accomplish this, rules are established for the benefit of the whole family. Each member is accepted as an individual with his or her strong points and shortcomings. Each member has his or her self worth validated by the unit as a whole. Rules are flexible according to the needs and capabilities of each individual. Change is encouraged and accepted. There is a free flow of open and honest communication.

In an addicted family system the attention of each member is focused primarily on the alcoholic/addict. Everything adjusts to accommodate the addict's use and behavior. The rules are established by the alcoholic or addict. The family reacts. At the same time there is denial that the chemical use is the problem. Change is discouraged. The status quo must be maintained to keep the pain within certain limits. Each person in the family has a set role and operates within the framework of that role. The role is maintained at the price of individuality. Since no one can say what they really feel there is no open and honest communication. Usually "the drinking" is never discussed.

The main enabler is usually the spouse. For the sake of brevity, we are going to assume he is the alcoholic or addict and she is the spouse. Her chief role is to protect the alcoholic/addict from the consequences of his chemical use. She may call work to report him sick and/or assume his responsibilities. She also tries to control his use. This may range from pouring out the bottle to chasing him from bar to bar, or from crack house to crack house. A more subtle form of enabling, but perhaps far more debilitating, is her tacit acceptance of the ever-increasing intolerable behavior.

As her role progresses she becomes even more isolated. She withdraws from church and community activities, perhaps in embarrassment. She becomes the perfect mother and a wonderful worker on the outside — a prisoner of unspoken feelings on the inside.

The Doctor's wife in the normal medical family is just that—"the doctor's wife." She is labeled and put on a pedestal from the beginning married to a title! "The doctor's wife" loses her name. Her identity revolves around the physician. Just by marrying a Doctor, most Doctors' wives inadvertently give up some individuality. "The Doctor's wife" by virtue of her title is already cut off from society. With addiction she experiences intensified isolation. This is changing in today's world, but this has been the pattern in the past.

In most Doctor's families everything revolves around the physician: his work, his schedules, his stress, his moods. Everything adjusts so he can practice most effectively.

This is the perfect set-up for addiction. Many of the mechanics are already in place. Therefore, it is easier for the family to become enmeshed. I see two areas that are different in the addicted medical family from the usual addicted family. Both are differences in degree, not in kind. The dynamics are the same, just exaggerated.

The first has to do with the unique position of the physician's family in society. It is on a pedestal. The Doctor is dealing with life and death and is therefore considered elevated above everyone else. So there is the terror of public exposure, of professional censure, and of the disintegration of a highly valued professional and social status.

Therefore, the Doctor's wife will go to almost any extreme to prevent anyone from finding out—including lying to patients, nurses and friends. Generally by the time the patient arrives in treatment the wife has not confided the situation to a single soul. In some cases her denial is so high the wife is unaware that her behavior is beyond normal limits.

The second area involves recovery. The same terror prevents her from seeking help. Even after he is in treatment it prevents her from going to self-help groups. His reputation is at stake. Doctors' wives will more often choose treatment in preference to Alanon or Naranon for two reasons. First, the medical setting is familiar to them. Secondly, the confidentiality is

---

\*Chaplain, South Miami Hospital, Addiction Treatment Program.

guaranteed.

In co-dependency treatment they begin to break down barriers. They start to experience feelings in a safe place. They begin to trust. This process facilitates the spouse's entry into Alanon or Naranon and an ongoing program of recovery.

The bottom line in the family is that as the disease progresses, there is a gradual deterioration of the individual — often this process is outpictured with physical symptoms. There are emotional and mental imbalances, and there is a loss of spirituality.

The spiritual deterioration starts with the first lie to the children, or to the nurse on the phone. Her value system has been compromised. The guilt has begun.

There are as many definitions of spirituality as there are thinking people. They all revolve around an idea of harmoniously relating to ourselves, to our neighbors and to a Higher Power. There is a perception of an underlying unity of all.

Einstein, in his theory of relativity, revealed the world to be a four dimensional continuum. Thus, all man's perceptions of the world and all his abstract intuitions of reality...merge finally into one and the deep underlying unity of the universe is laid bare.<sup>1</sup> He said:

"A human being is a part of a whole, called by us the 'Universe,' a part limited in time and space. He experiences himself, his thoughts and feelings as something separated from the rest — a kind of optical delusion of his consciousness. This delusion is a kind of a prison for us, restricting us to our personal desires and to affection for a few persons nearest to us. Our task must be to free ourselves from this prison by widening our circle of compassion to embrace all living creatures and the whole of nature and its beauty.

Nobody is able to achieve this completely, but the striving for such achievement is in itself a part of the liberation and a foundation for inner security."

John Donne said, "No man is an island." But the addicted family is an island. Their secret cuts them off from open communication with friends and acquaintances. It cuts them off from their support.

Since there is no open communication within the family, each person is his own little island. They are each alone within the family. Even though the spouse resists Alanon, she really has no choice. If she does not go to Alanon and the alcoholic or addict continues to use, she will proceed to become increasingly more dysfunctional. If she doesn't go to Alanon or Naranon, and alcoholic or addict recovers in AA or NA, she also loses because, by staying in her dysfunctional situation, communication is lost. When a person is in harmony with himself, with his friends and with his Higher Power, he sees the world as a safe place, a beautiful place and a joyous place. He rests secure on this foundation.

In Alanon or Naranon, one day at a time, with the help of others honestly triumphs, and amends are made. There is the beginning of peace or at least peaceful moments. Self esteem rises. With patience comes the ability to forgive the alcoholic or addict and herself. A program of meditation is instituted, and eventually there is an abiding serenity in the spouse, independent of, and not contingent upon, the path chosen by the addict or alcoholic.

#### Footnotes:

1. Barnett, Lincoln, "The Universe and Doctor Einstein," New York: William Morrow and Company, 1966, p72.

2. New York Post, November 28, 1972.

## Call PRN For Help

If you have a dependency problem, or you are the colleague, spouse or family member of a physician who does, help is only a phone call away. And it is absolutely confidential. Call PRN (Physicians' Recovery Network) 1-800-239-MASA or 205-263-6441

On weekends, after office hours and holidays call: 1-205-271-5759.





S. Lon Conner  
Executive Director, MASA

## Happiness and the Radical Middle

*Men can only be happy when they do not assume that the object of life is happiness.*

So wrote George Orwell in 1944 to his friend Arthur Koestler. Both the gifted authors were less than sanguine about the future of the human condition. Both were deeply troubled by what they saw in these war years and by what they feared was ahead for government institutions.

Orwell, particularly, feared that in the postwar world, the totalitarianism of communism would be every bit as cruel as Nazism had proven to be. He had no way of knowing then of the many thousands already exterminated by Stalin.

With two books (among many), *Animal Farm* and *1984*, he accurately predicted the course communism would follow for the next generation and longer. *Animal Farm*, a devastating attack on the claimed "classless society" of the Soviet Union, was held up for publication until the end of the war in 1945. Orwell's British publishers did not want to offend Stalin, an ally sorely needed by the Western democracies in crushing the Axis powers. Of course *Animal Farm* was the Soviet Union, thinly disguised.

This preface is necessary to explain the environment of the sentence from Orwell's 1944 letter to Koestler. It is, I believe, a profound observation that goes far to explain part of the malaise gripping Americans today.

When Thomas Jefferson fixed in the Declaration of Independence the "inalienable" natural rights of man, he numbered among these rights "life, liberty and the pursuit of happiness."

Jefferson believed that those who were least governed were best governed. Government would have minimal influence on human aspirations after providing the freedom for whatever individuals wanted to do with their lives. As defined by Jefferson and his peers, the essential freedom was the right to be left alone. And that certainly subsumed the right to be as free as possible *from* government.

It may be difficult to imagine today, but that right was a monumental one when compared to the lot of the average man in the Old World or in the colonies of the New World.

What a difference two centuries have made. The pursuit of happiness, in the minds of too many millions of Americans, has been federalized. They assume that the proper role of government is to make them happy.

If they are not happy, it is because of some failure on the part of government — city, county, state, nation. That was the battle cry after the L.A. riots: government had failed them; naturally, then, they had to loot, burn and kill. How else is possible to show that you are not happy and that the government is responsible?

In this as in previous columns I have been exploring the landscape of American political thought which provides the backdrop for consideration of health care reform. I cannot believe, from the dependent, cry-baby mood of the country, that the timing is auspicious. The vaunted American spirit is suffering from dry-rot.

This rot infects high and low. Just as we see masses in the inner cities demanding tribute or else,

# The ACCUPRIL Single-Agent Commitment<sup>TM</sup>

Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.\*†



ONCE-A-DAY ‡  
**ACCUPRIL<sup>®</sup>** <sup>TM</sup>  
quinapril HCl tablets 10, 20, 40 mg

\* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.



## Accupril® (Quinapril Hydrochloride Tablets)

### USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, ACCUPRIL should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Before prescribing, please see full prescribing information. A brief summary follows.

### INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

### CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

### WARNINGS

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).**

**Hypotension:** Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N=3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did not occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

**Fetal/Neonatal Morbidity and Mortality:** ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of ACCUPRIL as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, ACCUPRIL should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function. Removal of ACCUPRIL, which crosses the placenta, from the neonatal circulation is not significantly accelerated by these means. No teratogenic effects of ACCUPRIL were seen in studies of pregnant rats and rabbits. On a mg/kg basis, the doses used were up to 180 times (in rats) and one time (in rabbits) the maximum recommended human dose.

### PRECAUTIONS

#### General

**Impaired renal function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

**Evaluation of hypertensive patients should always include assessment of renal function** (see DOSAGE AND ADMINISTRATION).

**Hyperkalemia and potassium-sparing diuretics:** In clinical trials, hyperkalemia (serum potassium  $\geq 5.8$  mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

**Cough:** Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent, and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

**Surgery/anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients

**Pregnancy:** Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

**Angioedema:** Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

**Symptomatic hypotension:** Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an

## Accupril® (Quinapril Hydrochloride Tablets)

excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

**Hyperkalemia:** Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

**Neutropenia:** Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

### Drug Interactions

**Concomitant diuretic therapy:** As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

**Agents increasing serum potassium:** Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

**Tetracycline and other drugs that interact with magnesium:** Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

**Lithium:** Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

**Other agents:** Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

### Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m<sup>2</sup> basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinapril were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively).

### Pregnancy

**Pregnancy Categories C (first trimester) and D (second and third trimesters):** See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

### Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in human milk; caution should be exercised when ACCUPRIL is given to a nursing mother.

### Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinapril compared to values observed in younger patients; this appeared to relate to decreased renal clearance rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

### Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

### ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal pain	1.0 (0.2)	0.7

See PRECAUTIONS, Cough.

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N=4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

**General:** back pain, malaise

**Cardiovascular:** palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypotensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

**Gastrointestinal:** dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

**Nervous/Psychiatric:** somnolence, vertigo, syncope, nervousness, depression

**Integumentary:** increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

**Urogenital:** acute renal failure

**Other:** amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

**Fetal/Neonatal Morbidity and Mortality**

**See WARNINGS, Fetal/Neonatal Morbidity and Mortality.**

**Angioedema:** angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

### Clinical Laboratory Test Findings

**Hematology:** (See WARNINGS)

**Hyperkalemia:** (See PRECAUTIONS)

**Creatinine and blood urea nitrogen:** Increases (71.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

\*In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

PD-103-MI-7457-C1(052)



**PARKE-DAVIS**

A Warner-Lambert Company  
Morris Plains, New Jersey 07950



so do we have moguls of industry demanding insulation from foreign competition. Right now the auto industry is trying to convict Mazda and Toyota of "dumping" their minivans on the American market. Dumping in this context means selling below what should be their reasonable costs.

One item in the bill of particulars is revealing: American auto makers say that Japanese costs contain too small a percentage of administrative overhead. The American auto industry has been top-heavy with administrative costs. If the Japanese don't feel these are necessary or desirable, that's cheating. Presumably Washington will force Mazda and Toyota to factor non-existent administrative costs into their prices so as not to have an unfair advantage over the Americans.

Absurd. Almost as absurd, in fact, as the very recent suggestion by U.S. trade officials that the Japanese cut back on the hours in their workweek so that we can be more competitive.

Despite these adverse signs and symptoms, the spirit of individualism and enterprise still exists, as evidenced by the hundreds of entrepreneurial businesses still being launched on a shoestring. Many fail, but some succeed brilliantly.

Steve Jobs, a college dropout, started Apple computer in a garage and endured the ridicule of his peers to create one of the great American success stories. The richest man in America is now Bill Gates of Microsoft, whose rise from obscurity was even more spectacular. He too rejected the industry's derisive laughter that he was tilting with windmills in his belief that he could produce software the world needed.

Neither man assumed that the object of life was happiness —and certainly not that the object of government should be to guarantee their happiness. They assumed only the biblical truth that "whatsoever thy hand doeth well, do it with thy might." They worked hard, against all odds, and were rewarded with creating something entirely new that benefits mankind in general and, in particular, the many thousands of their fellow men for whom they provided jobs.

It's probably safe to say that both found happiness, but the object of their quest was not the blissful state as such, but to have done somethings believed to be impossible.

Lest we forget, there are many others quietly press-

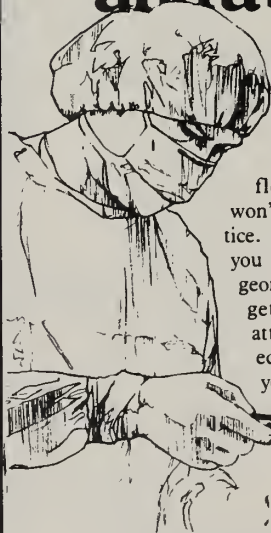
ing on in this old American way. But their stories are the more remarkable because such old-fashioned can-do drive and persistence stand out in stark contrast to the general mood of a nation which seems to have lost its way. And such heroes as Jobs and Gates are only heroes in the industry. The general public favors celebrities who howl their unhappiness to the indifferent heavens.

Once Americans boasted; now we whimper.

The demands from the hitherto stable middle America, they who are now swarming to the candidacy of Ross Perot, have so surprised the political scientists with their demands for more and more from government that a new demographic label has been coined — "the radical middle."

How would ever be possible to design a health care bill that would placate people in such a profoundly self-pitying and demanding state?

# An Officer and a Surgeon



If you're a surgeon looking for a change of pace and a chance to sharpen your surgical skills, try your hand in the Air Force Reserve. Serve part-time. Our flexible participation schedule won't interfere with your private practice. Depending on your experience, you may qualify for the Flight Surgeon Program. As an officer, you'll get good pay, benefits and paid attendance to continuing medical education (CME) activities. Serve your country. Serve yourself. For more information, call (404)421-4892. Today's Air Force Reserve...it's a great way to serve.

**AIR FORCE RESERVE**

14-214-0004

**A GREAT WAY TO SERVE**





*Peter W. Morris, M.D.  
President, MASA*

## The Good Old Days Are Now

**P**rediction: In 20 years the late 1980s and the early 1990s will be the good old days. You will remember them as the best of times for medicine.

The point being that the good old days were never as good as the version that survives in memory, which has a way of filtering, revising, embellishing, sanitizing and Simonizing the past.

This process begins early in life. Remember your derisive laughter in grade school when parents repeatedly told you that these times would one day be remembered as the happiest period of your life? The here and now is always burdened by vexations and irritations that fade with time. The common expression, "Someday we can look back and laugh at all this," bespeaks an awareness of the process of selective and cosmetic recall.

I can tell you that the good old days of my practice life were not all that great. The only thing we had for hypertension when I started out was phenobarb and the rice diet, which more or less committed the patient to a life of a Chinese coolie's cuisine.

The antibiotics were hardly adequate by today's standards, miraculous though they seemed then. We had none of the monitoring and imaging of today's technology, which have totally eclipsed the relatively primitive tools of my good old days.

But wasn't a physician much more free then to practice his art and science without the intrusions and limitations of third parties? Yes, of course, but I think it was Ralph Waldo Emerson who enunciated the law of human compensation — for everything we lose we gain something; for everything we gain, we lose something. In essence, there is a price for everything

and there is usually a corresponding benefit.

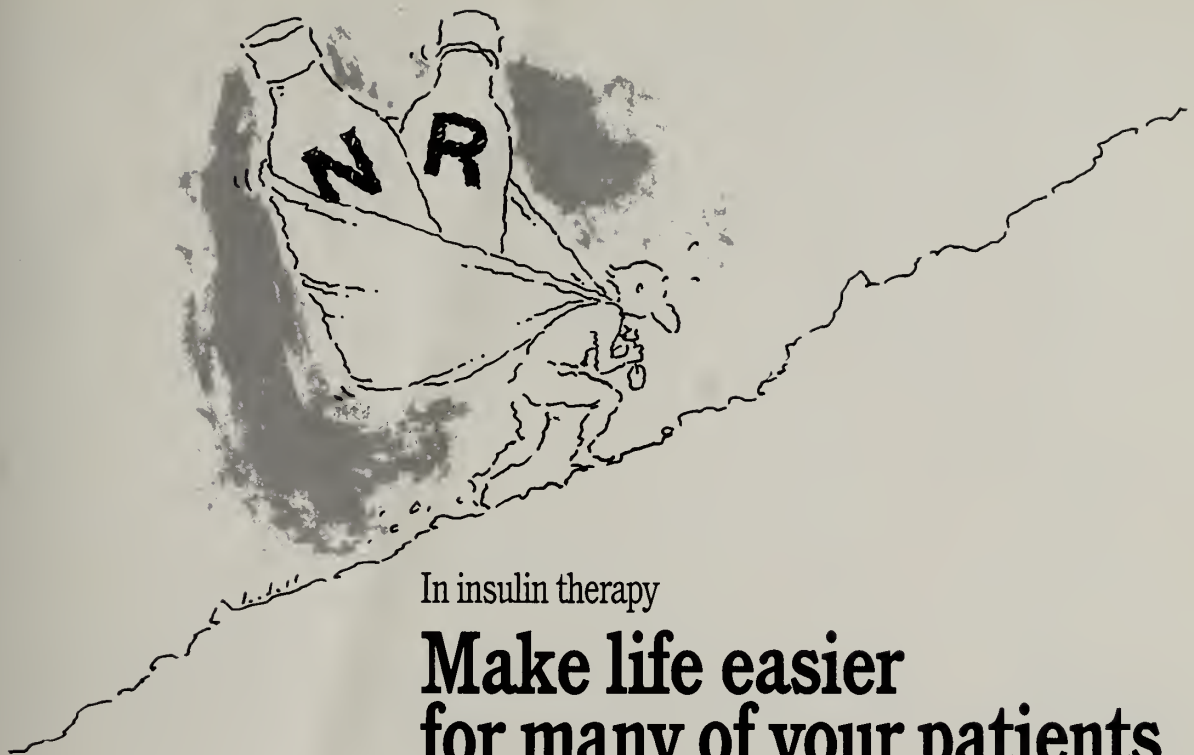
Modern medical technology, marvelous as it is, is exorbitantly expensive and as far as the prophetic eye can see, it will remain so. Demand for this high-tech medicine seems infinite; but resources are finite.

These opposing forces are fast approaching critical mass, the awareness of which has produced all the conniptions we see on the national political scene. "The aura of inevitability," described by *JAMA* Editor George D. Lundberg, M.D., in his brutally frank editorial of May 13, predicts a necessary ceiling on capacity and utilization "no matter how distasteful or politically dangerous that may seem to be."

Failing that, he said, Congress will procrastinate too long and may be panicked into federalizing the health care system, seizing control of hospitals and conscripting doctors and nurses. As far-fetched as that eventuality may seem, Dr. Lundberg is not the first to note its possibility when weighing the exponential growth of health care expenditures against the seeming paralysis of the political process to act and act rationally while there may still be time.

That would be an unqualified disaster for patients, doctors and the nation. But given the public's adamant opposition to paying for what it wants from the country; given the disabling fear of political leaders to challenge that; given the country's historic inability to act before disaster strikes — Dr. Lundberg's scenario of a "meltdown" of the health care system by 1996 is not unthinkable.

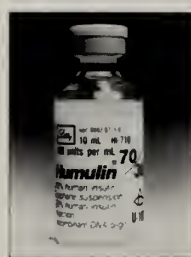
A doubling of national health care expenses every five years, or less, has made the threat a real and present danger, he writes; something must give, and fair-



In insulin therapy

## Make life easier for many of your patients

Humulin 70/30. Convenient and simple to administer.



No more mixing. No more mixing errors.  
All of which makes living with diabetes a  
little easier for patients. And compliance  
a lot easier to achieve.

# Humulin<sup>®</sup> 70/30

70% human insulin isophane suspension  
30% human insulin injection  
(recombinant DNA origin)



Global Excellence in Diabetes Care

Eli Lilly and Company  
Indianapolis, Indiana  
46285

*The patient-friendly premix*

**WARNING:** Any change of insulin should be made cautiously and only  
under medical supervision.

HI-7905-B-249327 ©1992, ELI LILLY AND COMPANY



ly soon, are everything may be sucked into a black hole of wholly catastrophic consequences.

Both the savings & loan and the junk bond debacles were preventable, as Dr. Lundberg notes sadly, but were not prevented. Obviously he fears the same abdication of responsibility in the looming health care debacle. I share his belief that the only salvation must come from our own ranks:

"... I believe that medicine is different from the savings & loan and Wall Street businesses. I believe that physicians are professionals. We know that true professionalism means self-governance, self-determination, and ethical behavior in the public interest. To merit still being called professionals, we physicians

will have to prevent the anticipated meltdown in advance, by preventive, scientific, educational and political action — now.

"... All players and all stakeholders will have to compromise — the patients, the physicians, the insurance companies, the hospitals, the government, the politicians, and all the special interest groups. But the essence of compromise means that the major players all give up something and get something...."

If we do have the statesmanship to assume the lead in well as fiction.

But if we fail to rise to the challenge, the public will never forgive us. Nor will we forgive ourselves.

## CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

USAF HEALTH PROFESSIONS  
TOLL FREE  
1-800-423-USAF



# FREEDOM FROM PAIN!

THE FRANCIS A. COUNTWAY  
LIBRARY OF MEDICINE  
BOSTON, MA

AUG 8 1992

**Extra strength pain relief  
free of extra prescribing  
restrictions.**

- Telephone prescribing in most states
- Up to five refills in 6 months
- No triplicate Rx required

## Excellent patient acceptance.

In 12 years of clinical experience, nausea, sedation and constipation have rarely been reported.<sup>1</sup>

COMPARATIVE PHARMACOLOGY OF TWO ANALGESICS					
	Constipation	Respiratory Depression	Sedation	Emesis	Physical Dependence
HYDROCODONE		X			X
OXYCODONE	XX	XX	XX	XX	XX

Blank space indicates that no such activity has been reported. Table adapted from Facts and Comparisons 1991 and Catalano RB. The medical approach to management of pain caused by cancer. *Semin. Oncol.* 1975; 2: 379-92 and Reuler JB, et. al. The chronic pain syndrome: misconceptions and management. *Ann. Intern. Med.* 1980 588-96.

## The heritage of VICODIN<sup>®</sup>,\* over a billion doses prescribed.<sup>2</sup>

- VICODIN ES provides greater central and peripheral action than other hydrocodone/acetaminophen combinations.
- Four to six hours of extra strength pain relief from a single dose
- The 14th most frequently prescribed medication in America<sup>2</sup>

**vicodin ES** 

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming) and acetaminophen 750mg)

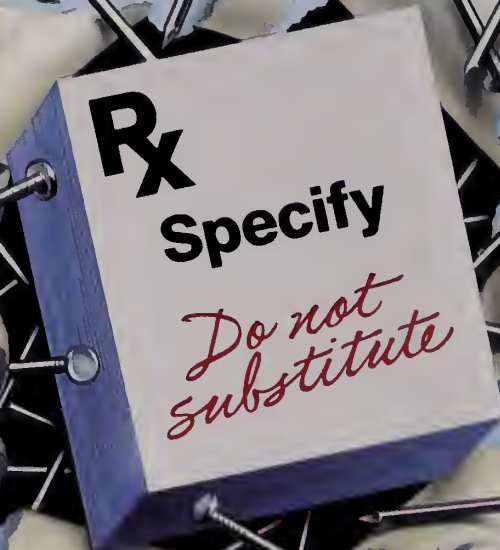
**Tablet for tablet, the most potent analgesic you can phone in.**

\* (hydrocodone bitartrate 5 mg [Warning: May be habit forming] and acetaminophen 500mg)

1. Data on file, Knoll Pharmaceuticals  
2. Standard industry new prescription audit



# Maintain control of your patient's therapy.



## vicodin <sup>®</sup> ES

(hydrocodone bitartrate 7.5mg (Warning: May be habit forming)  
and acetaminophen 750mg)

### It's your prescription – not a suggestion.

**INDICATIONS AND USAGE:** For the relief of moderate to moderately severe pain. **CONTRAINDICATIONS:** Hypersensitivity to acetaminophen or hydrocodone. **WARNINGS:** Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression. Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries. **Acute Abdominal Conditions:** The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions. **PRECAUTIONS:** Special Risk Patients: VICODIN/VICODIN ES Tablets should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when VICODIN/VICODIN ES Tablets are used postoperatively and in patients with pulmonary disease. **Drug Interactions:** Patients receiving other narcotic analgesics, antipsychotics, anxiolytic agents, or other CNS depressants (including alcohol) concomitantly with VICODIN/VICODIN ES Tablets may exhibit an additive CNS depression. The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone. The concurrent use of anticholinergics with hydrocodone may produce paralytic ileus. **Use in Pregnancy:** Teratogenic Effects: Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled studies in pregnant women. VICODIN/VICODIN ES Tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. **Nonteratogenic effects:** Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased stools, sneezing, yawning, vomiting, and fever. **Labor and Delivery:** Administration of VICODIN/VICODIN ES Tablets to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used. **Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from VICODIN/VICODIN ES Tablets, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include: **Central Nervous System:** Drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, psychic dependence and mood changes. **Gastrointestinal System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. Prolonged administration of VICODIN/VICODIN ES Tablets may produce constipation. **Genitourinary System:** The antiemetic phenothiazines are useful in suppressing the nausea and vomiting which may occur (see above); however, some phenothiazine derivatives seem to be antianalgesic and to increase the amount of narcotic required to produce pain relief, while other phenothiazines reduce the amount of narcotic required to produce a given level of analgesia. **Respiratory Depression:** Hydrocodone bitartrate may produce dose-related respiratory depression by acting directly on the brain stem respiratory center. Hydrocodone also affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. If significant respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride. Apply other supportive measures when indicated. **DRUG ABUSE AND DEPENDENCE:** VICODIN/VICODIN ES Tablets are subject to the Federal Controlled Substance Act (Schedule III). Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, VICODIN/VICODIN ES Tablets should be prescribed and administered with caution. **OVERDOSAGE:** Acetaminophen Signs and Symptoms: In acute acetaminophen overdosage, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Renal tubular necrosis, hypoglycemic coma, and thrombocytopenia may also occur. Early symptoms following a potentially hepatotoxic overdose may include: nausea, vomiting, diaphoresis and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours post-ingestion. **Hydrocodone Signs and Symptoms:** Serious overdose with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. In severe overdosage, apnea, circulatory collapse, cardiac arrest and death may occur.

Revised March 1992

5890

Knoil Pharmaceuticals  
A Unit of BASF K&F Corporation  
Whippany, New Jersey 07981



# Alcohol: Yesterday and Today

## Have We Changed?

Sean Allison  
and  
Thomas W. Sheehy, M.D.\*

Recently, one of us received a letter from the American Medical Association pointing out the prevalence of alcoholism in our society, its frequent misdiagnosis and its cost to society in general. Since, alcoholism is not a new problem, we thought a look at its use and misuse in ancient societies might be enlightening.

### The Beginning

Most likely, man's first encounter with alcohol was a fortuitous accident that will remain forever shrouded in the mist of time. Roueche believes that alcohol originated sometime in the late Paleozoic era, i.e. about 200 million years ago.<sup>1</sup> By then, water and plant sugars had come into existence and with the appearance of yeast, the scene was set. For yeast has the enzymatic ability to convert (ferment) the sugar present in berries, grapes, grain, honey, etc, into alcohol and water.<sup>2</sup>

Alcoholic fermentation is a natural process and, our ancestors soon learned that fermented honey (mead) or grain (beer) or fruit (wine) did more than quench the thirst. Most historians believe that fermented honey was the original source of alcohol. Whatever the source, its effects were appreciated and soon thereafter, probably in the neolithic age, its production became a reality. Some historians have suggested that agriculture was the result of an attempt to produce a regular source of material for alcohol production. As Edgar Anderson noted, "man may well have been a brewer before he was a baker."

Initially, beer and wine were used for sacramental purposes and primitive societies guarded their pro-

duction with a variety of rituals and taboos. In some, brewers were forbidden to have sex while engaged in preparing the brew. In others, women were forbidden to drink. According to Greek historians, kissing began when men wanted to know if their women folk had been sipping. A kiss on the lips was the test.<sup>3</sup> In all primitive societies, the indiscriminate use of beer or wine was forbidden. Alcoholism and the drunkard were non-existent. They are a product of civilization.

By the third millennium (BC), cuneiform writings indicate beer was brewed for pleasure. One transcript unearthed at Niva (1926) indicated wine was among the stores taken aboard the Ark. It reads, "for our food, I slaughtered oxen and killed sheep and with beer, oil and wine, I filled large jars." The Old Testament also notes that Noah, "drank of the wine and was drunken."<sup>1</sup>

This same era produced the first known written account of drunkenness: "if a man has taken strong wine his head is affected; he forgets his words and his speech becomes confused; his mind wanders and his eyes have a sad expression."—and—the first cure for hangover; "to cure him, licorice, beans and oleander — are compounded with oil and wine." Today, this prescription minus the beans, oleander and licorice would be akin to cure by taking the "hair of the dog that bit you."<sup>1,2</sup>

In the Old Testament, drunkenness is condemned but not the use of alcohol. Proverbs states: "Give strong drink unto him that is ready to perish—and wine unto those that be heavy of heart." Strong drink probably refers to the cereal brews (beer) used by the Hebrews. In that language, *shikar* means beer and is of the same root as *shikur*, drunkard.<sup>4</sup> It was customary for the Hebrews to dilute their wine with water, thus, decreasing its potency. This practice was also

---

\*From Department of Medicine, University of Alabama Medical Center at Birmingham, Alabama.



prevalent in Greece and Rome and persists today in the Mass. In Roman society, it was considered barbaric to drink undiluted wine. Whether, this was due to the poor taste of water or because unadulterated water often caused diarrhea is unknown. The accepted ratio was one part wine to two parts water. Some Romans believed that drinking undiluted wine would lead to madness. They were unaware of lead poisoning—which most likely was responsible for the “Mad Emperors” of Rome.

Egyptian hieroglyphics indicate that drunkenness was prevalent amongst all classes in the 17th dynasty.<sup>1</sup> One mural in a tomb near Luxor, depicts a tavern owner welcoming a patron and inviting him to “drink unto rapture.” Herodotus gave us a glimpse into that time. “After dinner, a man carries round an image of a corpse in a coffin and says: “Drink and make merry, but look on this, for such shalt thou be when thou art dead.””

Findings in older tombs likewise provide evidence that vinaculture was widely practiced during the first dynasty, circa 3000 B.C. As wine became popular in Egypt, vineyards spread south along the Nile. Eventually, Egyptian wine jars were labeled with the name of the vineyard, the date of the harvest, the pressor’s name and the brand. One wonders if they advertised.

Taverns, too, were prevalent in Egypt and in Babylon and they were a problem. As a result, Hammurabi (2100 B.C.), devoted two of his famous codes just to their control.<sup>1,2</sup> Greece and Rome had their gods of wine, their taverns and their debauchery. Plutarch (325 B.C.) tells us of drunken orgies amongst Alexander’s Macedonian Army. During one of these, Alexander reportedly set fire to Persopolis, the ancient capitol of Persia, an incident he regretted for the remainder of his life. The 150 foot “Monte Tastaccio,” adjacent to the coliseum in Rome is in reality an enormous mound of broken wine jars, evidence of the huge quantities of cheap Spanish wine consumed during Roman games. A friend of mine suggested Monte Tastaccio may have been the first land-fill.

Eastern civilizations used spirits just as readily as those in the West. Shu Ching in the ancient Chinese *Cannon of History* 650 B.C. points out, “Men will not do without beer”—“to prohibit it and secure total abstinence from it, is beyond the power even of sages.” Moderation was prescribed by no less an authority than Genghis Khan, who wrote; “A soldier must not get drunk oftener than once a week. It would be better if he didn’t—but one should not expect the impossible.””

## Alcohol as a Medicinal

The medicinal use of alcohol also stretches into antiquity. In the oldest medical text in recorded history (a Sumerian physician’s prescription book written about 4,000 years ago), beer was included in many prescriptions.<sup>3,4</sup> The *Ebers Papyrus* dated 1550 B.C., refers to the medicinal use of alcohol. The *Hearst Papyrus*, written about the same time, notes that beer was the vehicle in 27 prescriptions and wine in 12.<sup>7,8</sup> Most of these prescriptions were given for the relief of pain.

In Greek and Roman society wine and beer were utilized for a variety of diseases.<sup>9</sup> Mnesitheus classified medicinal wines as light, medium and dark. Dark wines were given for strength, medium for digestion and light for diuresis. Special brands were often prescribed for their therapeutic effects, *e.g.* Egyptian wine for diuresis, Signine wine for diarrhea, Spanish wine for bladder disease, and the wine of Thasos as a soporific.<sup>9</sup>

These societies also realized that alcohol had injurious effects. Both Pliny and Aristotle cautioned that wet nurses should not drink wine for fear of its ill effects on the infant.<sup>9</sup> Aristotle even proclaimed that wine was injurious during pregnancy, anticipating by centuries the “fetal-alcohol” syndrome. But this idea is even older for in *Judges 13:7*, an angel tells Samson’s mother: “Behold, thou shalt conceive and bear a son: and now drink no wine or strong drink.” Hypocrates and Pliny, both, noted the power of wine to damage man’s health. Pliny forbade the use of wine by patients with sexual problems, hypertension, lock-jaw and fever.<sup>9</sup> Aristotle claimed “a sober body is of sounder constitution than a drunken one.”

Hangovers were well known to the ancients. The frequency of headaches after heavy drinking led the Romans to bind their temples with cloth. Eventually, this gave rise to the practice of wearing garlands, while the frequent prescription of spirits as medicinals by physicians gave rise to the Roman habit of taking cocktails before meals.<sup>9</sup>

## The Middle Ages and Onward

800 AD marks a monumental date in the distillers history. About this time, the process of distillation was discovered by “Jabir Ibn Hayyan or Geber,” an Arabian. Geber’s description was so vague that Samuel Johnson thought the word “gibberish” was derived from his name.<sup>1</sup>

Distillation was immensely important for it gave man the ability to improve upon the yeast’s productivity. By separating alcohol from its sugars, he obtained



# Silence Is Not Golden

Is your malpractice carrier silent except when they want money? If you have questions, are you connected to someone who can answer them?

You *won't* get the silent treatment at ICA, and you *will* get answers from real people who care about you and your practice.

**Call Us,  
We'll Really Talk.**

From the CEO... to the President... to an Underwriter... to a Claims Attorney... we'll talk to you about the importance of the consent-to-settle clause, our tough stand on claims, risk management, and credits to reduce your premium, anything of interest to you.



Insurance Corporation of America  
4295 San Felipe P.O. Box 56308  
Houston, Texas 77256-6308  
1-(800)-899-2356 (713) 871-8100

**Defending Defensible Doctors**



the pure product.

Five hundred years, later, Arnauldus De Villanova, a Professor of Medicine at Montpellier reintroduced alcohol as a medicinal. He clearly described a method for distilling wine to obtain, what he called, "Aqua Vitae" or the "Water of Life." According to De Villanova, it "prolongs life, clears away ill humours, revives the heart and maintains youth."<sup>1</sup> The fact that De Villanova lived into his 70's, a rare event in those days, may have led to the rapid acceptance of aqua vitae as a medicinal. Aqua vitae was the liquor, now known as "brandy," or distilled wine. It became an instant medical success.

Four hundred years later, in another monumental step, Franciscus Sylvius, a Professor of Medicine at the University of Leyden, learned to distill alcohol from grain. Flavored with juniper to mask its raw taste, it became "gin." The Russians discarded the flavor and called it "vodka" or "little water."<sup>1, 10</sup>

### **The 18th & 19th Centuries**

Soon, the demand for this new "Aqua Vitae" increased across all of Europe, and in 18th century England, the government encouraged its production. The campaign was so successful that within 50 years the production of gin rose from less than 1 to over 20 million gallons per year and led to the greatest national debauch of all times.<sup>1,10</sup> The use of gin was so common, in England, and it cost so little, that Mothers even fed their babies gin to quiet them. Then the government tried to enforce moderation through passage of the "2-gallon tax." This prohibited the sale of gin in less than 2-gallon quantities. The increased cost led the populace to revolt in the "London gin riots." Shortly after repeal of this law, the government began to impose taxes on the sale of gin, a custom that perseveres to this day. It also became customary for employers to provide their employees with spirits during working hours. Whether the drudgery of 12-hour working days encouraged this practice, or whether it began as an ill-conceived attempt to increase productivity remains a moot point.<sup>8</sup> But eventually, this practice came into question. In 19th century Connecticut, a group of business leaders decided not to provide anything stronger than beer or cider to their employers. To their surprise, they found employees were more efficient without daily rations of spirits.<sup>8</sup>

The existence of "Scotch" or "highland brew" even antedates that of brandy. It first appeared in Ireland where it was made from "malted barley" and was brought to Scotland by Irish invaders in the 6th century A.D. "High-land brew" remained a drink native to

these countries until 1860, when Andrew Usher blended highland brew (malt whiskey) with pure grain whiskey (neutral spirits) to give us today's Scotch. Soon, Scotch gained ascendancy over Brandy and port as the favorite drink of the English nobility.

### **Spirits from the New World**

From the New World came three new beverages. In Mexico, Cortez found the natives drinking pulque (the fermented sap of the century plant). The Navajos and Inca's also prepared pulque or maguey wine. Distilled pulque is tequila. From the Caribbean came "rum" or "rumbullion" the alcoholic essence of fermented molasses. By the end of the 17th century, the manufacture of rum was New England's largest and most profitable trade. This led to increased slavery and to the so called "rum triangle." Gradually, rum was replaced by a cheaper, more readily available product that originated in the United States.

This third major contribution was "whiskey." The early Scotch-Irish settlers on the American frontier had a long acquaintance with "hill whiskey." So, they began to make it for local consumption and for economic reasons. Transportation was difficult and possible only by horse, mule or barge. As H.F. Wilkie noted: "A horse, which would carry only four bushels (of corn) in solid form, could carry 24 bushels in liquid form." So, in early America, almost all farmers made whiskey. Indeed, the medium of exchange in early Pennsylvania and Maryland was rye. When Alexander Hamilton placed a tax on these spirits, it led to the "Whiskey Rebellion." But, the hardest of all corn currencies was "Bourbon." Kentucky Bourbon was first made by Elijah Craig, a Baptist clergyman from Royal Spring in Bourbon County, Kentucky.

### **Saturnine Gout**

Meanwhile, distillers in Europe continued to create new or to improve older types of wine. Earlier, we mentioned that in the absence of air, yeast ferments sugar solutions to alcohol and carbon dioxide. The latter makes the brew bubble. The alcohol is actually excreted by the yeast but when the concentration reaches 13% the yeast dies in its own excrement.<sup>2</sup> Therefore, "unfortified" wines never have an alcohol concentration above 13%. To increase the potency of sherry and port and other "fortified" wine, alcohol is added.

Fortified port was responsible for the epidemic of "saturnine gout" that afflicted the English nobility in the 18th and 19th centuries. The Portugese, who had sided with Britain in the War of the Spanish

# **THE UNITED STATES ARMY RESERVE HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM**

## **\$10,000 - \$20,000 - \$30,000**

The **1989 National Defense Authorization Act** required that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army. The 1991 National Defense Authorization Act directed that the test continue.

The Bonus Test Program is offered to physicians in the following specialties:

**ANESTHESIOLOGY  
ORTHOPAEDIC SURGERY  
and  
GENERAL SURGERY**  
*(Including selected subspecialties)*

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

**BONUS ELIGIBILITY:** In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

**BONUS AMOUNTS:** The test offers \$10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

**TEST PARAMETERS:** The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

**TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM  
PLEASE CONTACT:**

**U.S. ARMY RESERVE HEALTH CARE TEAM  
2100 16th AVENUE SOUTH, SUITE 306, BIRMINGHAM, AL 35205-5201  
OR CALL COLLECT: (205) 930-9719 or 9727**



Succession, were later allowed to ship their wines into England at one-third the tariff imposed on French wines. To prevent spoilage, they "fortified" their port with brandy. Portuguese brandy was stored in lead casks, and over time acquired high concentrations of lead. By 1825, the English were importing 40,277 tuns of port annually. (A tun is equal to 138 US gallons.) Later, Ball showed that port, bottled between 1770-1820, contained large amounts of lead.<sup>11</sup> Hence, the epidemic of saturnine gout.

Today, the alcoholic content of most beverages is expressed as "proof." This stems from the 17th century English custom of estimating alcoholic content by moistening gun powder with the beverage and lighting it.<sup>12</sup> The lowest concentration that would ignite—about 57% alcohol by volume—was "proof" spirits. Hence, 100 proof today equals approximately 50% alcohol content.

### Alcohol in the USA

Today, there are over 15 million alcoholics in the United States, and 25% of them suffer the complications of alcoholism. Among various states, California rates highest in the number of alcoholics, 80 per 1000 population. Alabama has 25 alcoholics per 1000 population.

Eighty percent of alcoholics are under age 50 years, and 1 in 4 are under age 30 years. About one-half of all alcoholics are married and live with their wives; three out of four live in established households. Nine of ten have lived in their present town for at least two years. Seven of ten hold jobs requiring skills; about 60% have held steady employment for three years. In the United States, alcoholism is associated with 50% of the homicides, one-third of the suicides, and about one-half of all traffic accidents. In 1990, over 22,000 persons died in alcohol-related traffic accidents.<sup>12</sup> One-half of all felons in federal penitentiaries have alcohol-related problems.

Alcoholism is fourth among the nation's health problems, and is outranked only by heart, cancer and mental illnesses.

Alcohol consumption is highest in the Northeast and lowest in the South. The official per capita consumption in the USA is about three gallons per year over age 14 years. Three gallons is equivalent to 320 (12 oz) cans of beer, plus 12 bottles of table wine, plus 11 bottles of distilled spirits.<sup>1</sup> However, most of this alcohol is consumed by a small percentage of the population. In the U.S., 35% of the total population are abstainers and 55% drink less than three drinks per week. Ten percent of the drinking population con-

sumes 50% of all the alcohol. Most heavy drinkers are in the 20-35 year age range but 7% of men and 2% of women over 65 years are also heavy drinkers.

Only the politician is ambivalent about alcoholism as suggested by the address given to the Mississippi State Legislature by one of its Senators in 1958.<sup>1</sup>

"You have asked me how I feel about whisky. All right, here is just how I stand on this question:

"If, when you say whisky, you mean the devil's brew, the poison scourge, the bloody monster that defiles innocence, yea, literally takes the bread from the mouths of little children; woman from the pinnacles of righteous, gracious living into the bottomless pit of degradation and despair, shame and helplessness and hopelessness, then certainly I am against it with all of my power.

"But, if you when you say whisky, you mean the oil of conversation, the philosophic wine, the stuff that is consumed when good fellows get together, that puts a song in their hearts and laughter on their lips and the warm glow of contentment in their eyes; if you mean Christmas cheer; if you mean the stimulating drink that puts the spring in the old gentlemen's step on a frosty morning; if you mean the drink that enables a man to magnify his joy, and his happiness, and to forget, if only for a little while, life's great tragedies and heartbreaks and sorrows, if you mean that drink, the sale of which pours into our treasuries untold millions of dollars, which are used to provide tender care for our little crippled children, our blind, our deaf, our dumb, our pitiful aged and infirm, to build highways, hospitals and schools, then certainly I am in favour of it.

"This is my stand. I will not retreat from it; I will not compromise."

Have we changed? What do you think?

### BIBLIOGRAPHY

1. Roueche B, - *The Neutral Spirit: A portrait of Alcohol*. Little Brown Co. Boston 1960.
2. Goodwin DW, - *Alcoholism: The Facts*. Oxford University Press 1981
3. Smith B, - *The Joy of Trivia*. Brookhouse, 1967 p6.
4. Keller M, - Beer and Wine in Ancient Medicine. *Quar. J. Stud. Alc.* 1958;19:153-154.
5. Kramer SN, - From the tablets of Sumer. Indian Hills, Colo; Falcon Wing Press. Ch 9-p56-60.
6. Kramer SN, Levey M, - The oldest medical text in man's recorded history. A Sumerian physician prescription book of 4000 years ago. *Illus. London News.* 1955;226:370-371.
7. Reisner GA, - *The hearst Medical Papyrus*. Univ. Cal. Publ. Egyptian Archeology. Vol I Leipzig, Hinrichs, 1905-20.
8. Keller M, - Alcohol in Health and Disease: Some historical perspectives. *Ann. NY Acad. Sci.* 1966;133:820827.
9. McKinlay AP, - Bacchus as health-giver. *Quart. J. Stud Alc.* 1950 230-246.
10. McCarthy RG, - Douglas EM, - Alcohol and Social Responsibility: A new educational approach. Ty Crowell Co. NY, NY. 1949 pl5-16.
11. Ball GV, - Two epidemics of gout. *Bull. History of Medicine* 45: 401-408.
12. Editorial: Annual and New Year's day alcohol related traffic fatalities, U.S. 1982:1990 *JAMA* 1992;267:214-215.



## Blue Cross Can Put Your Office On-line For Faster, Easier Claims Payment.

It's a simple operation called electronic claims submission. Blue Cross will provide you with a terminal that links you with our computer. Then, all you have to do is enter your claims. There's nothing to sort, sign, or mail. And your claims are processed faster and more efficiently.

Computer claim service is dependable, easy and cost effective.

For more information call us at 988-2588. Or write to Provider Services, Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35298.



**Blue Cross  
and  
Blue Shield**  
of Alabama

*The Caring Company.*

® Registered Marks Blue Cross and Blue Shield Association



# Fluidotherapy

## Clinical Applications and Techniques

*Richard T. Herrick, M.D., F.A.C.S.\**

*Stella Herrick, A.T.*

### Introduction

Fluidotherapy is a unique, multi-functional physical medicine modality. Its therapeutic effectiveness in rehabilitation and healing is based on its ability to simultaneously apply heat, massage, sensory stimulation for desensitization, levitation, and pressure oscillations. Unlike water, the dry, natural media does not irritate the skin or produce thermal shocks. This allows for much higher treatment temperature than with aqueous (water) or paraffin heat transfer media. The pressure oscillations actually minimize edema (swelling), even at very high treatment temperature, making a whole range of medical applications possible. Outstanding clinical success has been reported not only in the treatment of pain, range of motion, wounds, acute injuries, swelling and blood flow insufficiency, but also in treatment of sickle cell anemia, diabetic neuropathy, thromboangiitis obliterans (Berger's disease), and other etiologies which normally do not respond to heat therapy for which classical heat therapy has been contraindicated.

### Physical and Engineering Principles

An air-fluidized solids medium is formed by uniformly distributing air through the bottom of a bed of finely divided particles. The resulting state, termed fluidization, is established by the particles becoming microscopically separated from each other by the rising gas. This "fluidized bed" of particles has unusual properties which differ markedly from either those of the gas or of the particles. Remarkably, the fluidized bed behaves instead like a low viscosity fluid, exhibiting characteristics which are generally attributable to a liquid state.

This property permits submergence of parts of the

body into the fluidized bed and the suspension of these parts very much like in a liquid phase. The patient can exercise in the bath almost as freely as in water and can perform a variety of resistive exercises.

In addition, the heat transfer characteristics within the fluidized bed and to parts submerged in it are similar to that obtained in a mildly agitated liquid. This combination of gaseous phase flowing around the particles, the high surface area of the finely divided particulates and the bulk movement of solids, yields high heat transfer fluxes and temperature uniformity throughout the phase.

The solid Cellex<sup>®</sup> media used in most Fluidotherapy beds is derived from natural, organic cellulose (corn cobs). In some applications, polypropylene beads are used. Transfer of the kinetic energy of the particles to an immersed limb results in strong, stimulating counter-irritation and pain relief in accordance with the MelzakWall and other pain theories.

### Therapeutic Mechanisms

The counter-irritation, through mechanoreceptor and thermoreceptor stimulation, reduces pain sensitivity, thus permitting high temperature without painful heat sensations.

The pronounced hyperthermia accelerates the reaction time of the chemical metabolic processes and increases cell division, thus accelerating normal healing processes.

At high temperatures, there are tissue elasticity-enhancing effects and viscosity reductions which contribute substantially, through physio-chemical mechanical means, to the improvement of musculoskeletal mobility (flexibility).

The extensive and long-lasting hyperthermia, which is important for the supply of substrates and the disposal of metabolic waste products, is caused

---

\*Member, Medical Commission F.I.Q., Herrick Clinic, Post Office Box 4160, Opelika, Alabama 36803-4160

by the direct relaxing heat effects on vascular musculature, and reflex processes with lowering of the vasoconstrictive activity of the sympathetic nervous system. Also, the promotion, by heat input, of evaporative processes not possible in a liquid medium, results in increased liquid transfer, including dissolved substances, through those epidermal layers which are not vascularized, thus increasing their metabolic rates.

Fluid pumping in the vascular and other body systems is assisted by pressure fluctuations and kinetic energy transfer process occurring in the fluidized bed, thus enhancing vascularity and controlling swelling and edema due to extra or intra-cellular fluid accumulation.<sup>6</sup>

## **Clinical Indications**

### **Treatment of Pain**

Scientific basis: Mechanical and thermal stimulation of the skin produces counter-irritation which modulates sensory input, thus blocking pain perception and response. <sup>2, 4, 7, 12, 15, 17</sup>

Indicated for: Pain following injuries to tissue (muscle, nerve, skin or tendon) or from contusions, extension, distortion or luxation of the joints. Pain due to degenerative, rheumatic tissue alterations, overstrain (arthritis, arthroses, pain from Sudek's dystrophy, tenosynovitis, epicondylitis, tennis elbow), herniated nucleus pulposus, post-laminectomy, lumbosacral and mid-thoracic sprains and strains, unspecified low back pain and infarctions (such as sickle cell anemia). The stimulation is also very effective for producing desensitization in hypersensitive patients such as the hypersensitivity experienced by an amputee, or for those who have sustained nerve damage (i.e. neuromas).

### **Treatment for Range of Motion**

Scientific basis: The higher temperature in pathologically altered tissue achieved using fluidotherapy acts upon some tissue components (synovia, exudates, fibre structures) insofar as it lowers viscosity or improves elasticity respectively, altering rheological properties, thus improving the range of motion in a physiomechanical way. <sup>2, 7, 8, 10, 11, 12, 13, 16</sup>

Indicated for: dermatogenous, tendogenous, myogenous, neurogenous, and arthrogenous contractures (after injuries, inflammations, immobilizations, ischemia, disturbances of muscle innervations and in the case of rheumatic and degenerative alterations of the tissue). Restricted range of motion due to frac-

tures, reconstructive surgery, sports injuries and arthritis also responds well.

### **Treatment of Blood-Flow Insufficiency**

Scientific basis: Blood vessel dilation resulting from the very high treatment temperature, increases blood flow dramatically. <sup>3, 8, 9, 12, 18</sup>

Indicated for: Vascular insufficiency, insofar as this syndrome can be influenced by heat. Disturbances of sympathetic denervation by Sudek's dystrophy, Raynaud's Syndrome, as a symptom after cerebral ischemic insults (strokes) by constitutionally conditioned inclination to peripheral vasoconstriction (cold hands and feet in the case of vegetative dystonia); organic vascular diseases and their successive stages (e.g., stasis ulcers) insofar as it is possible to achieve an increased blood flow by hyperthermia. One must be extremely careful if there is any loss of sensation involved.

### **Treatment of Wounds, Swelling and Cutaneous (Skin) Disorders**

Scientific basis: The high temperatures accelerate the biochemical reactions involved in cell division and regeneration of new, healthy tissues. The drying effect of the gaseous phase enhances wound closure and scab formation. <sup>2, 9, 12, 16, 17, 18</sup>

Indicated for: Post-operative muscle, tendon and nerve repair; open wounds resulting from ulcers, surgical procedures for accidents; closed, traumatic or post-surgical wounds and swellings following injury to the extremities (contusions, dislocations, luxations, sprains).

### **Treatment of Arthritis Conditions**

Scientific basis: Thermal and mechanical stimulation relieves pain, increases blood flow and range of motion, thus permitting return of normal joint activity. <sup>2, 10, 12, 14, 16</sup>

Indicated for: Degenerative and rheumatic arthritic conditions of hands, feet, wrists, ankles, knees, lumbar vertebra, sacroiliac and lower cervical vertebrae.

## **Protocol**

### **General Protocol**

1. The patient should be positioned comfortably, with support for the back, and at a height which permits entry of the body part without strain. The part to be treated should be submerged in the medium before activating the blower. There is no thermal shock



when heat is applied through fluidotherapy.

2. Treatments are approximately twenty minutes in duration. Recommended temperature varies by body part and patient tolerance, but the range is approximately 110°F to 125°F (43.3°C to 50.56°C). Maximum benefits are derived when the highest treatment temperature that the patient can comfortably tolerate is used. See "Treatment Protocol" for specific temperature recommendations. Maximum temperature rise in the treated part occurs after 15 minutes of treatment. For this reason treatment times of less than 15 minutes are not usually recommended.

3. Unless contraindicated, active and passive exercise during treatment should be encouraged. Most fluidotherapy units permit the therapist to assist the patient in exercise through special entry ports. For example, exercise is indicated following joint injuries, minor skin damage, after amputation, for muscle weakness, in the convalescent phase of rheumatoid

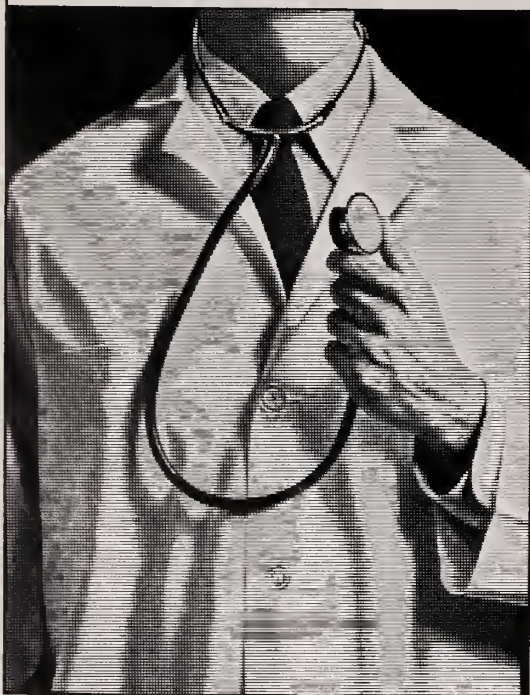
arthritis, or any condition in which the injury involves restricted range of motion. In cases where pain is significant, exercise may follow treatment when the affected area has been relaxed and pain has been reduced.

4. In case of open lesions or infections, a light, non-occlusive dressing is recommended to prevent soiling or contaminating the cloth entry ports. Should an occlusive wrapping such as a plastic glove be utilized, treatment temperatures should be two or three degrees above the norm because of the temperature gradient through the wrapping.<sup>5</sup>

5. Patients may be treated with splints, bandages, tape, orthopaedic pins, screws, plates, silastic joint replacements and artificial tendons.

6. The medium is clean and will not soil clothing. It is not necessary to disrobe in order to get the full benefit of heat and massage, however, direct contact between skin and the medium is desirable to maximize heat transfer.

## **FAMILY PRACTITIONERS: THE ARMY OFFERS YOU A THRIVING PRACTICE WITH UNIQUE ADVANTAGES.**



Army medicine offers you a ready-made family practice, from soldiers and their families to retirees, and we won't tie you down with paperwork because we have trained people to do all that for you.

And here are some other advantages to consider:

- no malpractice premiums
- medical facilities run by physicians
- the rank and privileges of an Army officer
- choice of first assignment—Europe, the Orient, Hawaii and major U.S. cities
- fully funded continuing medical education and conferences
- 30 days of paid vacation

It could be to your advantage to talk to an Army physician or visit an Army hospital or medical center to see for yourself what we have to offer. An Army Medical Counselor can assist you. Call collect

**ARMY HEALTH CARE TEAM**

**(404) 362-3359 or 363-5823**

**ARMY MEDICINE. BE ALL YOU CAN BE.**

## Indications

Abrasions	Factitious ulcers	
Amputations	Fibrosis	
Analgesia	Fracture (post)	
Ankle sprains	Furuncles	Necrosis
Ankle strains		Neurofibrosis
Arthritis	Gangrene	Neurogenous contractures
Avulsions	Gastrocnemius sprains	
Back pain	Gout	Organic vascular diseases
Bites	Granulomatous ulcers	Osteoarthritis
Bone injury		
Bruises		
Berger's Disease		Pain
Burns	Healing	Pathologic lesions
Bursitis	Heel spurs	Periarthritis
	Hematoma	Peripheral circulatory disorders
Calcific Bursitis	Herniated nucleus pulposus (ruptured disks)	
Carpal-Canal Syndrome		Phalangeal fractures
Carpal Fractures	Hypertensive ulcers	Phlebitis
Causalgia		
Chilblain ulcers	Infections	Range of motion
Circulatory disorders	Inflammation	Raynaud's syndrome
	Immobilization (post)	Reconstructive surgery
Contractures	Ischemia	Reflex dystrophy
Contusions	Ischemic ulcers	Rheumatic tissue change
Decubitus ulcers		Rheumatoid arthritis
Degenerative tissue	Joint capsule degeneration	
Dermatogenous contractures	Joint inflammation	Rheumatoid spondylitis
Diabetic neuropathy		
Dislocations	Lacerations	
Dupuytren's contractures	Laminectomy (post)	Sacroiliac strains
	Ligament injuries	Sciatica
Dystonia	Livedo reticularis	Sclerodermatous ulcers
Dystrophy	Lumbosacral sprain	Sickle cell anemia
	Luxations	Skin injury
Ecchymosis		Spasticity
Edema	Metacarpal fractures (post)	
Epicondylitis	Spinal injuries	
Epidermal defects	Metatarsalgia	Sports injuries
Epiphysitis	Muscle relaxation	Sprains
Epithelial wounds	Muscle rheumatism	Stasis ulcers
Excoriation	Myogenous contractures	Strains
Sudeck's Dystrophy	Tennis elbow	Vascular disease
Swelling	Tenosynovitis	Vasoconstriction
Sympathetic Ganglia	Thrombophlebitic ulcer	Vegetative dystonia
		Vertebral fractures (post)
Tendinitis	Traumas	Wound healing
Tendogenous contractures		
	Ulcers	
Tendon grafts	Ulcis cruris	



## **Treatment Protocol**

### **Treatment of the Spine, Hip and Thoracic Area**

Herniated nucleus pulposus (ruptured disks), after laminectomy, arthritis of the spine, compression fractures (traumatic or osteoporosis), lumbosacral and mid-thoracic sprains and strains, simple stable vertebral fractures and spasticity in spinal cord injury: Temperature recommended is 115 -125°F (46.1°-51.7°C) for 20 minutes. Hot packs are sometimes applied to the neck during treatment to enhance relaxation. The patient may be positioned on his/her side for maximum treatment of the hip or thoracic area. After fluidotherapy, the patient is most receptive to exercise to promote range of motion, strengthen muscles and strengthen the afflicted area. Treatments may be administered two to three times a week for three to four weeks, but some patients prefer to experience the relief of pain and relaxation provided by daily treatments.

### **Treatment of the Hand, Wrist, Elbow**

In all of the following, the recommended treatment temperature is 112°-118°F (44.4°C-47.8°C) for 20 minutes unless otherwise indicated.

Carpal (wrist), metacarpal (hand) and phalanged fractures: It is recommended that treatment begin as soon as possible after the onset of the injury and continue daily or as often as possible after the onset of the injury until range of motion is close to normal and pain is no longer significant. Active, assistive, and passive exercises may be engaged in during treatment following a 10-minute warm-up period, or exercise may follow treatment. Fluidotherapy may be used when orthopaedic pins are in place.

Tendon repairs: Beginning four to six week after surgery and continuing for four to six weeks for relief of pain and to enhance range of motion.

Tendon grafts: Treatment often begins two months before surgery to maintain normal passive range of motion during utilization of tendon rods. Fluidotherapy is then recommended for three to four weeks after surgery, continuing for four to eight weeks, thereafter.

Burns: Lower temperatures are recommended, usually 110°F (38.8°C). If there are open lesions, a light non-occlusive dressing is used. Treatment is recommended for three to four weeks after surgery (or skin graft) to accelerate healing and reduce pain.

Complicated lacerations: Treatment should begin as soon as possible after onset of injury. Sutures (stitches) present no problems. Fluidotherapy prepares the limb for exercises if there is joint stiffness or symptoms of reflex sympathetic dystrophy.

Rheumatoid arthritis: Recommended for pain, stiffness and active assistive range of motion exercise. Fluidotherapy may be used if patient has splints following joint replacement.

Osteoarthritis: Treatment recommended primarily for reduction of pain and to prepare the hand for active assistive and passive exercise. Treatment recommended for as long as six weeks, although some osteoarthritis suffers find treatment a helpful ongoing regimen.

Carpal tunnel median nerve compression: Treatment is sometimes useful before surgery for reduction of pain and maintaining range of motion. As soon as the skin is healed and the sutures are removed after surgery, Fluidotherapy treatments for two to four weeks accelerate internal healing and restoration of function. Treatments may be continued longer in case of complications.

Tennis elbow: Treatment recommended at least once daily for seven to ten days. Reduction of pain may be noticed starting with the first treatment.

Amputations: Starting 10 days to two weeks after amputation of a finger, toe, foot, or hand, treatment is uniquely useful in the desensitization of nerve endings, thus hastening readiness for other treatment modalities. The strength of the bombardment of the cellulose particles (fluidization) can be adjusted as the patient's tolerance increases. Pain reduction and healing take place dramatically with a course of three to four treatments per week over several weeks.

### **Treatment of the Foot, Ankle and Knee**

Heel spurs, plantar fasciitis, fractures, ankle sprains and strains, post surgical conditions, epiphysitis, metatarsalgia ("Jogger's foot"), gastrocnemius strain, arthritis, ulcers, and Berger's disease. Recommended temperature is 110°F-118°F (43.3°C -47.8°C). Treatments last approximately 20 minutes at frequencies which suit the patient's convenience, but preferably several times per week until reduction of pain or healing has occurred.

Ulcers caused by external causes (trauma, burns or decubitus) or internal causes (arterial, venous, stasis, anemias or systemic) respond well to multiple treatments over a period of 4-12 weeks at temperatures of from 112°-118°F (44.4°-47.8°C). In the case of neuropathy, treatment temperatures of 121°-123°F

(49.4°-50.6°C) can be applied .

### Miscellaneous Medical Applications

Human or animal bites, acute gout and pseudo-gout, dry and wet gangrene, partial thickness burns, jagged lacerations, avulsions, puncture wounds, abrasions, muscle pulls and tears, hematomas, partial fingertip amputation and sickle cell anemia. As an integral part of the treatment of the above conditions, Fluidotherapy should be initiated as early as possible and (except in the case of burns) utilized at the highest degree of heat comfortable for the patient. There appears to be a definite thermal antibiotic effect, in addition to the healing, induced by increased blood flow and penetrating heat. Fluidotherapy has been frequently utilized as part of the management of partial fingertip amputation with quick results. In the case of diabetic neuropathy, the deep vessel dilation provides comfort lasting several weeks or months after a series of several treatments per week for two weeks. Sickle cell treatment protocol is detailed in Reference 17.

### Contraindications

In case a serious circulatory obstruction such as an arterial occlusion (blockage), or similar obstruction in the venous or lymph system exists, heat or drugs which enhance circulation should be applied with extreme caution . In these and other cases where individual over-sensitivity to heat is thought to exist, one should use low temperature and carefully monitor the patient for swelling, pain, intense color changes, or other symptoms indicative of low heat tolerance.

Other possible contraindicating conditions include hepatitis, chicken pox, typhoid, paratyphoid, sepsis, and other serious infectious diseases, and/or diseases where it is advisable, for general medical purposes, to suppress fevers .

### Summary

Fluidotherapy is a modality of great utility in almost all sports medicine problems of the extremities and spine, and should be considered to help enable the athlete to return to practice/competition as quickly as possible.

### Bibliography and References

1. Borrell, R.M., Henley, E.J., Ho, P., et al.: Fluidotherapy: Evaluation of a New Heat Modality. *Arch Phys Med Rehab* 58: 6971, 1977.
2. Borrell, R.M. and Henley, E.J.: Fluidotherapy in a Hand Clinic. *Arch Phys Med Rehab* 60:536, 1979.
3. Borrell, R.M., Parker, R., Henley, E.J., et al.: Comparison of In Vivo Temperatures Produced by Hydrotherapy, Paraffin Wax Treatment, & Fluidotherapy. *J of Amer Phys Ther Assoc* 60 (10): 1273-1276, 1980.
4. Brown, D.M. and Ellis, R.: A Physiological Basis for Desensitization of the Hypersensitive Upper Extremity. Paper presented at American Society of Hand Therapists, Las Vegas, 1980.
5. Evans, J.A.: Microbial Sterilization Using Fluidized Beds. *Bioengineering and Biotechnology* 24: 263-264, 1982.
6. Fan, L.T., Ho, T.C., Hiraoka, S., and Walawender, W.P.: Pressure Fluctuations in a Fluidized Bed. *AIChE Journal* 27: 388-395, 1981.
7. Fuentes, L. F. and Lopez, D.A.: An Evaluation of a New Heat Modality: Fluidotherapy. Paper presented at Natl APTA Meet, Atlanta, 1979.
8. Henley, E.J.: A Novel Fluidized-Bed Application: Fluidotherapy. *CHEMTECH*, April, 215-220, 1982.
9. Lober, S.: Quantitative Analysis of Fluidotherapy Heat Treatment on the Human Hand: Thesis. Houston, TX, Univ of Houston, 1980.
10. Lopez, D.A.: Evaluation of Fluidotherapy Units. US Govt Memorandum, VA Hosp System, May, 1978.
11. Reinstein, L.: An Evaluation of Fluidotherapy. Dept of Rehab Med, U of Maryland Sch Med, Preliminary Report, *Amer Acad Rehab Med*: 6/4/80.
12. Valenza, J., Rossi, C., Parker, R., and Henley, E.J.: A Clinical Study of a New Heat Modality: Fluidotherapy. *J Amer Pod Assoc* 69: 440-442, 1979.
13. Anonymous: Hand Clinic. *The Journal, Methodist Hosp, Tex Med Cen, Houston*, 17(10):16, 1978.
14. Finsferwald, K.L., Christler, P., Cory, M., Leeper, L., and Muser, s.: Fluidotherapy Versus Paraffin: Clinical Comparison in Rheumatoid Arthritis. *Proceedings of the Fifth Southeastern Regional Meeting, Arthritis Health Professionals*, Williamsburg, VA, p. 45, 1982.
15. May, H.U., Mayer-Waarden, K., and Nippel, F.: A New Method for More Effective and More Comfortable Application of Heat Using the Counter-Irritation Principle. *Schmerz*, 2:114-117, 1981 (In German).
16. Watson, J.E., Harris, J.F., and Henley, E.J.: In Vivo Temperature Elevations Using Dry Whirlpool Therapy. *Equine Practice*, 6(7): 11-14, 1984.
17. Alcorn, R., Bowser, B., Henley, E.J., and Holloway, V.: Fluidotherapy and Exercise in the Treatment of Sickle Cell Anemia. *J Amer Phys Ther Assoc*, 64(10):1520-1522, 1984.
18. Rossi, C. and Henley, E.J.: Treatment of Lower Extremity Ulcers with Fluidotherapy. *Podiatry Today*, April:17-24, 1985.



# The Crisis of Rising Health Care Cost: A Physician's Perspective

*Steven Stokes, M.D.\**

For decades, American medicine has led the world in scientific and technological advances. We have seen dramatic strides in the treatment of heart disease, cancer, and organ transplantation. Our system has provided patients with the ability to choose their physicians and hospitals. Physicians have remained as the patient's advocate and not agents of the government or other business interest to the patient's detriment. However, this high tech medical care has not been without cost.

Increasingly, Americans are lacking access to this care. Presently it is estimated that 33-36 million Americans do not have any health care coverage. Who are these individuals? Approximately a third are the working poor. These are above the poverty line and typically employed with small companies of less than 25 employees that do not provide health care benefits. Another third have an adequate income, however, they have voluntarily elected not to purchase commercial insurance or have inadequate insurance that fails to provide adequate coverage for catastrophic illness. There are also those who have a pre-existing medical condition for which their current insurance does not provide benefits. The remaining third are unemployed or below the federal poverty line. Some of these are covered by Medicaid with the remainder being indigent with no coverage. If one examines their age, you find that one third are less than 25 years of age, one third are 25-35 years of age, and the remainder are 35-65. Once individuals are over 65, they are typically covered by Medicare.

The remaining 85% of the population is covered by

a patchwork consisting of Medicaid, Medicare, or commercial insurance. Providing coverage has become expensive. Health care cost now consumes 650 billion dollars per year or approximately 12% of our gross national product, the highest in the world. It now costs an estimated \$2,500 to \$3,000 per year for every man, woman, and child for health care coverage. Last year health care cost increased by 10.5% and over the past three years has been running in the double digits due to inflation, increasing volume of services, and increasing intensity of service. These dual problems of increasing costs and loss of coverage are resulting in a mandate for change. As national elections approach in 1992, health care in America will be a dominant issue.

In order to arrive at a solution, it is important to understand the driving forces behind increasing cost. Our population is aging and patients over the age of 65 demand greater volumes and intensity of medical care.

Federal mandates have also required states to increase eligibility for Medicaid. This joint state and federal program is frequently thought of primarily providing prenatal and child care to the poor; however, it also is a substantial source of coverage for long term chronic care of the elderly. Between 1980-1989, the number of Medicaid recipients increased by 9%, the cost by 123%, consuming a greater share of the average state's budget 9-14%.

Sophisticated technology also plays a major role in rising cost. It has been estimated that technology is responsible for 75% of accelerated health cost over the past few years. Newer sophisticated equipment also requires additionally trained technical personnel and physicians. Technology, such as cardiac angio-

---

\*Past President, Houston County Medical Society

plasty, magnetic resonance scans, and organ transplantation, has improved the quality and duration of life and by doing so allowed patients to survive requiring future health care and additional cost. Death is cost-effective.

Proliferating malpractice litigation and the physicians response of defensive medicine add substantially to the cost of care. Although the numbers are difficult to obtain, the best estimates are that additional diagnostic studies and over treatment as protection against malpractice may add an additional \$21 billion per year. Between 1982-1990 the average physician's malpractice premium increased from \$5,800 to \$15,500 per year. This resulted in an annual rate of increase of 15% per year. Even state Public Health Departments are suffering from malpractice cost. As many as 80% of school children in some Alabama counties receive their school immunizations at County Health Departments. Since 1978, the minimum cost per child for immunizations has increased from \$3.67 to \$64.17. Much of this increase is due to a surcharge imposed to handle claims against vaccine manufacturers.

Traditionally, hospitals and to some extent physicians have been able to cover the increasing cost of health care to uninsured patients by a process of "cost shifting." By this process, commercial insurance companies are charged additional rates to offset delivering care to patients without funds. However, the point is being reached where commercial insurance carriers and businesses are unable and unwilling to pay additional sums such that patients without coverage can receive the same high quality of care as patients with coverage. The nation's business community is demanding single-digit annual increases in health care cost while maintaining high quality care for its money. In an increasingly international market where American companies must compete, it is understandable that they cannot continue to pass on to their customers these rising costs of providing health care to their workers which now composes an average 26% of their production cost.

The dissatisfaction with the American health care system by business, workers, government, and health care providers is impetus for seeking solutions to America's health care problems. Of the world's developed countries, only America and South Africa do not provide universal health care coverage to their citizens. A variety of mechanisms is in place worldwide to provide universal health care coverage and these are now being evaluated to determine if they will be applicable for America.

There is a perception by some legislatures that the Canadian health insurance system is simple and as a whole could be transplanted to the United States. Congress has already instituted a form of the Canadian system by setting hospital and physician fees for the Medicare program. This represents a major effort on the part of the government to obtain cost control on rising health care cost by limiting hospital and physician charges.

Canada's health care program is a nationwide federal/provincial health insurance system publicly funded and privately delivered. The system covers all residents for all medically necessary inpatient coverage and outpatient hospital services. All of Canada's 25 million residents are eligible for health insurance. Earlier practices of physicians extra billing and hospital user charges were eliminated in 1984. The Canadian public expects universal health coverage and are willing to be taxed for the services provided. The nature of financing health insurance for hospital and physician services is simple in that it is done through federal block grants and transfers of payments to the provinces directly. This simplicity means that the Canadian system is 80% less costly to administer than health care in America. Planning and distribution of health care is centralized. The provincial governments set global budgets for hospitals. By controlling new beds and the introduction of new services or technology, the Province controls the volume of health care delivered.

By limiting new services or technology, indirect rationing of care is imposed. As an example, using 1989 data, Canada had one open heart surgery unit per 813,000 people while the U.S. had one unit per 307,000 people. Canada had one cardiac catheterization unit per 667,000 people while the U.S. had one unit per 198,000 people. These capacity constraints result in longer patient waiting for entry into the hospital or access to advanced technology based on medical priority.

There are no financial barriers to care. Patients who need open-heart surgery in British Columbia, for example, may wait up to seven months while those requiring repair of even simple vaginal lacerations may wait a year. Radiation treatments for cancer may be delayed as much as one and a half months. Despite these delays, the majority of Canadians seem satisfied with their health care system and are willing to endure inconvenience and discomfort for the advantage of universal coverage.

After careful scrutiny, consensus seems to be building that the Canadian system will not be applica-



## US THEM



**Postgraduate  
Medicine**

**WHEN YOU NEED  
TIME ON YOUR  
SIDE, THE CHOICE  
IS CLEAR. °**

**NO CLINICAL  
CLUTTER—  
PGM ARTICLES  
ARE CLEAR,  
CONCISE, WELL  
ILLUSTRATED,  
AND PRACTICAL.**

ble-to the U.S. There are subtle differences in the U.S. and Canadian public. Here in America we demand immediate access to appropriate medical care when it is needed rather than when the system can accommodate us on the waiting list. The population of the U.S. is tenfold that of Canada and we have a higher percentage of elderly, poor, minority, and high-risk individuals than Canada. In the U.S., 10% of our population accounts for 70-80% of national health expenditures.

A 1989 Lou Harris poll showed 68% of Americans favoring nationalized health care system. However, of those who supported national health care, less than half are willing to pay more than \$50 a year in additional taxes for such coverage. Studies have shown that it would require a minimum of \$500 per year additional taxes to fund a Canadian style system in the U.S. Only one state in the U.S., Oregon, has moved toward providing near universal coverage for its citizens. Examining their problems will serve to highlight the difficulties in applying universal health coverage nationwide. The Oregon program speaks directly to the dilemma in controlling health care cost by rationing.

Liberal citizens view public pensions, welfare, health and other programs as social contracts between government and its citizens. Conservative citizens view public entitlement programs as an open invitation to excess as interest groups, liberal voters, technological progress and other expansionary forces encourage everyone to want every health care need satisfied at the taxpayers expense. The necessity is to find a common ground of compromise between these two extremes. Despite these wide differences, there is a growing fascination with rationing.

Conservatives realize the hard but obvious truth that a society trying to reduce big government and budget-busting deficits with increasingly limited resources but unlimited expectations must find dependable and defensible ways to say no. Liberals, fearful that the poor will be trampled in the scramble for self protection that follows each political mandate to cut budgets and taxes, view rationing as a politically accountable approach to allocating benefits that give the disadvantaged equal access. Both ends of the political spectrum are becoming aware that the irresistible forces of rising cost, consumer demands, and surging technological innovation with its associated cost are meeting an immovable object of the unwillingness of public and private health care providers to invest unlimited sums to deliver health care. In short, paying patients are no longer willing to subsidize

nonpaying patients.

Since 1982, Oregon has been vigorously debating strategies to cover the medically uninsured. In 1987, the state put itself at the head of the rationing revolution by refusing to fund certain organ transplants under Medicaid on the grounds that many such procedure buy a small increment of additional life at a high cost and that money from such endeavors could be better utilized. Soon following this decision, a child was denied a transplant and died, throwing Oregon's rationing adventure into the national spotlight. Undeterred, state leaders argued that Oregon had tackled the hard choices and was attempting to devise a rational plan for health care. An 11-member health services commission sponsored 11 public hearings, 47 town meetings, and a telephone survey to learn the values and preferences of the average citizen on the relative priority of medical treatments. The commission then compiled a list of 800 medical procedures and applied to it a quality-of-well-being scale that measures the cost of services and their contribution to the longevity and quality of life. An insurance actuary then attached cost coefficients to individual items. When implemented, the state legislature, after considering its fiscal situation, will draw a line along some level on the list. By law it cannot rearrange items on the list. Procedures above the line will stay eligible for Medicaid payment while those below will no longer be covered by the program. It was argued that savings on the less effective procedures are intended to enable the state to expand Medicaid eligibility, bringing in an additional 118,000 citizens.

However, Medicaid is not an exclusive state program but is jointly administered by the Health Care Financing Administration (HCFA). The state requested a waiver from HCFA to allow them to institute the program; however, the intense debate over the appropriateness of denying coverage for certain conditions such as AIDS has prevented the issuance of the waiver. Opponents of the program have argued that Medicaid services for poor mothers and children are being limited while coverage of the aged and disabled is exempt. Opponents have also argued effectively that the vulnerable and politically disorganized poor are being penalized while the organized senior citizens are being exempted from health care rationing. At present, Oregon is still seeking a compromise with HCFA to allow them to implement their program. Such intense controversy explains why national political leaders have been hesitant to engage in a health care debate.

However, this changed when the Democratic can-

didate, Harris Wolford, defeated his heavily favored Republican opponent, Dick Thornburg, for senator of Pennsylvania after calling for a vaguely defined "national health insurance program."

President Bush had been studying health care proposals but had hoped to delay a debate on the issue until after the '92 election. The Democratic candidates for president and top Democrats in Congress have drafted health care proposals that differ substantially from President Bush's, forcing the issue.

The Democratic proposals have ranged from creating a government insurance program like Medicare that would cover everyone, including chronic, long-term care, to measures that would force every employer to provide health insurance to employees or pay taxes to fund a broad public insurance plan. President Bush's program does not propose a plan for long-term chronic health care coverage. It does propose phasing in tax credits for individuals and families with incomes up to 150% of the federal poverty level, which currently is approximately \$20,000.00 for a family of four. The tax credits refundable to the poor would help defray the cost of purchasing insurance in the private market. However, there is no provision in the event they elect not purchase an insurance plan. The President opposes mandates that would compel employers to provide health insurance, as proposed by the Democratic plan. The tax credits proposed by Bush would result in huge cost to the government, perhaps \$30 billion annually.

The centerpiece of President Bush's cost containment proposals is a push toward managed care, such as HMOs. There are also proposals for raising the Medicare premiums paid by high income beneficiaries with adjusted gross incomes greater than \$125,000 per year. Proposed measures also include fighting infant mortality and large funding increases to expand the government's program for community health centers.

Louis Sullivan, M.D., Director of the Department of Health & Human Services, is a strong proponent of preventive medicine and will emphasize prevention in future government plans. At present, 20% of all white babies, 30% of all Hispanic babies, and 70% of all black babies are raised in single-parent homes, initiating a cycle of poverty and poor health. Without reproductive restraint the cycle can never be broken. Many of our chronic debilitating diseases are self-inflicted. Alcohol costs the nation \$70 billion a year, resulting in 15,000 automobile deaths. Smoking remains America's No. 1 preventable cause of death, leading to 390,000 deaths per year. It results in 87% of all



deaths from lung cancer and 21% of all deaths from heart disease. This single habit costs the nation \$52 billion a year in death and disability. Any nationalized health care system should include efforts at changing America's lifestyle and penalizing (financially) those who continue these self-destructive habits.

As the election year proceeds, the debate on health care will be intense and a single solution will be inadequate. The quick-fix of limiting reimbursement to physicians and hospitals (of which over 100 per year are closing) is doomed to failure. Only by simultaneously attacking the increasing demands on services, rising malpractice cost, and proliferating technology, while extending universal health coverage, can we provide for our citizens.

There will be no easy solution in devising a new health care plan for America. The ultimate course will be that which is least painful. We must initiate an equitable dialogue between health care providers, payers, consumers and legislators to institute changes in our system and avoid its collapse. Traditional medical ethics demand that the physician remain the patient's advocate. Like the lawyer who fights for his client in the court of law, the physician must fight for his patient in the court of life. Physicians must not sacrifice a patient's well-being even if by doing so serves the economic welfare of society. If society ultimately decides that cost containment and implied rationing is the course they wish to pursue, then physicians must submit, but they must also continue to do their best for their patients within that level of reduced service and technology. To do any less relegates us to the role of "cost containment technicians" abandoning our heritage as the "patients advocate."

## INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper 8 1/2 x 11 inches with adequate margins. Two copies should be submitted. Authority for approval of all contributions rests with the Editor. *Alabama Medicine* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

**Style:** The first page should list title (please be brief), the author (or authors), degrees, and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month — day of month if weekly — and year. Number should be limited to absolute minimum. References should be numbered consecutively in order in which they appear in the text.

*The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk, Jr., and E.B. White, which emphasizes brevity, vigor and clarity.

Final authority on grammar is Webster's *New International*, Unabridged, Second Edition.

**Length of Articles:** Articles should not exceed 3,000 words (approximately 3-4 printed pages). Under exceptional circumstances only will articles of more than 4,000 words be published.

**Illustrations:** Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top, and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

**Reprints:** Reprint orders should be returned at once. Prices for reprints, based on number of pages, will be furnished upon request by MASA Services. Communications should be addressed by *Alabama Medicine*, The Medical Association of the State of Alabama, P.O. Box 1900, Montgomery, Alabama 36102-1900. Telephone (205) 263-6441, or (toll-free in Alabama) 1-800-392-5668.

# The 'Collector's Calendar'

## *I.C. System*

"Time, tide and past-due accounts wait for no one." Especially the creditor. For every day that passes in which no payment is received, the value of an overdue account to the creditor decreases and there is less probability that the debtor will pay.

What can you, as a creditor, do to offset this disadvantage? Since time will never be on your side, take action now and follow the "Collector's Calendar."

The calendar is a series of positive business practices which any creditor can implement to control outstanding accounts. It consists of these steps: first billing, second billing, inquiry/tracing, demanding/clarifying, negotiating, arranging, follow-up, persistence, and finally, legal action or write-off. The further along in the series you get, the lower your chances to receive payment.

**First Billing**—This is by far the most important action that a creditor can take: getting the bill into the debtor's hands as soon as possible is critical. In many cases, as time passes, the perceived value of a product or service rendered will lessen. Customers may not feel as obligated to pay as they would right after the purchase. Consequently, it is imperative that you get the bill to the debtor quickly, while the value of that product or service is still high.

Since most people pay following a first billing, here are some ways you can help ensure that will happen:

Present the bill when the service is rendered. Mail the bill immediately following the transaction. Do your billing more than once a month.

**Second Billing**—The majority of people who do not pay on the first billing will pay after a second one. The second bill should be sent to the debtor no later than 30 days after the first billing.

**Inquire/Trace**—When an account is 60 to 90 days past-due, it's time for the creditor to get in direct touch with the debtor and ask why payment has not been received. It is preferable for you to do this with a telephone call rather than a letter, since calling is often more effective in settling a bill.

**Demand/Clarify**—Once the debtor has been reached, request immediate payment in full. You should be prepared to clarify the bill: amount due, due date and the services rendered. The better you are able to answer any complaint the person has about the service, the better your chances will be to collect.

**Negotiate**—If immediate payment in full is not possible, you, the creditor, should make arrangements for installment payments. In some cases, when the service was unsatisfactory, a partial settlement may be negotiated.

**Arrange**—If an arrangement has been negotiated for partial or installment payments, end your call by settling on specific details for when payment is due. Make sure the debtor clearly understands the payment arrangement.

**Third Billing**—The third bill should be sent to the debtor immediately following telephone contact. The results of this billing will show if your debtor intends to honor his debt or if you are re-entering the cycle.

**Follow-up**—If you have reached this point in "The Collector's Calendar," without receiving satisfactory payment(s), it is very likely that your debtor will continue the pattern. At this point, additional phone calls to the debtor must be made, repetitive billing will continue, additional negotiations must begin, etc.

**Persist**—Debtors often use various delaying techniques in order to discourage a creditor from continuing collection procedures. Consequently, persistence is not only a virtue, it is a must.

**Legal action or write-off**—Now you are at the end of "The Collection Calendar" and are faced with one of two options: legal action or writing off the bill as a bad debt.

If this process seems like a lot of time-consuming work for staff, there is an alternative: the use of a third-party negotiator. In most cases, this will be a professional collection agency.

For most businesses, the investment in overdue accounts becomes unprofitable after 90-120 days. Staff time, overhead costs and frustration levels sap the concern's ability to move toward maximum profitability.

Generally, the most efficient accounts receivable management technique outlines a consistent business practice whereby all overdue accounts are turned over to professionals in the collection field at a pre-set moment in time, usually after the third billing. Employing professional collectors who are thoroughly trained and experienced in debt collection at this point makes economic sense for creditors.

I.C. System is the largest privately-owned debt management company in the country and is recommended by nearly 1,200 professional and business associations. Your association endorsed I.C. System in 1978 and recommends it as an effective and ethical debt collection service. I.C. provides a collection service specifically designed to meet the unique needs of members of the Medical Association of the State of Alabama. To learn more about I.C. System, contact MASA, 205-263-6441.





*Mrs. B. R. Mosley  
A-MASA, President*

## Inside-Out

*There is no real excellence in all the world which can be separated from right living.*

*David Starr Jordan*

Many individuals achieve an incredible degree of natural success but find themselves struggling with an inner hunger and deep need for personal effectiveness and for healthy, growing relationships with other people.

Quick-fix approaches cannot solve these problems. We must look at the lens through which we see the world as well as the world we see, and realize that the lens itself shapes how we interpret the world.

If we desire to change a situation, we first have to change ourselves. To change ourselves effectively, we first have to change our perceptions.

In the last 50 years there has developed in this country a great deal of literature dealing with the "personality ethic." The elements of the personality

ethic—personality growth, communications skills training, and positive thinking—are beneficial to success but they are secondary and not primary traits.

The "Character Ethic" must evolve as it did in the days of the founding of this country. Benjamin Franklin's autobiography is representative of the literature of an earlier day—the story of one man's effort to integrate certain principles and habits deep within his nature. Some of these habits were: integrity, humility, fidelity, temperance, courage, justice, patience, simplicity, modesty and the use of the Golden Rule.

The Character Ethic teaches that there are basic principles of effective living and a person can only experience true success and enduring happiness as they learn and integrate these principles into their basic character.

*Adapted from The Seven Habits of Highly Effective People by Stephen R. Covey, Simon & Schuster, New*

# ALABAMA MEDICINE CLASSIFIED

Classified advertising is \$27.00 for 30 words or less, plus 25 cents for each additional word, payable in advance. Classified displays are \$25.00 per column inch. Ad box number can be substituted for formal addresses upon request at a cost of \$5. Copy deadline is 6 weeks preceding date of publication. Send copy to: Advertising Manager, ALABAMA MEDICINE, P.O. Box 1900, Montgomery, Alabama 36102-1900.

**FPs and IMs desperately needed in Birmingham, Montgomery, and Tuscaloosa.** Compensation and benefits more than competitive. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**FP, IM, GP needed in rural South AL flourishing practice.** Guaranteed net income of \$150k, plus all expenses. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

**RADIOLOGY AT WOMAN'S HOSPITAL,** Baton Rouge, Louisiana. For the diagnostic radiologist interested in ultrasound, mammography, and CT, along with general radiology, in an expanding, highly respected Ob-Gyn specialty hospital. Construction is underway on completely new Radiology Department and Breast Center. Pleasant work environment, highly trained staff, excellent compensation, and very generous time off. Baton Rouge is a nice place to live, and is a short drive to New Orleans and the Gulf Coast. Call or write: Chet Coles, M.D. or James Ruiz, M.D., P.O. Box 95009, Baton Rouge, LA 70895, 504-924-8266, Fax: 504-924-8242.

**Ophthalmologist Wanted** for thriving, state-of-the-art eye practice in Columbus, Mississippi, seeking to add an associate leading to a partnership. Beautiful city of 25,000 with many varied recreational, social, and cultural activities. Competitive package. Contact Albert Laws, M.D. at (601)328-1254 or 2475 North 5th Street, Columbus, MS 39701.

**ER Physicians needed** for North Alabama (urban communities). \$130K to start, plus all expenses. Very accommodating schedules offered. Immediate vacancies. Send CV to P.O. Box 6002, Tuscaloosa, AL 35405.

## Affordable Term Life Insurance from Cook & Associates

Compare these low non-smoker annual rates for non-decreasing, yearly renewable term insurance:

Male ages	\$250,000	\$500,000	\$1,000,000
25	248	455	845
30	248	455	845
35	255	460	875
40	298	545	1,045
45	348	645	1,245
50	430	810	1,575
55	600	1,150	2,255
60	875	1,700	3,355
65	1,525	3,000	5,955

## Cook & Associates

Renewable to age 100. Female rates same as males six years younger. All coverage provided by companies rated "A+" by A.M. Best Co.

For a written quotation and policy description send your date of birth and amount of coverage desired to:

**P.O. Box 850517, Mobile, Alabama 36685-0517 • (205) 341-5168 • 1-800-239-3992**

Above rates are provided by Jackson National Life



# Newly Licensed Doctors

Hicks, Phillip Alan, M.D.  
Lloyd Noland Hospital  
Emergency Medicine  
701 Lloyd Noland Parkway  
Fairfield, AL 35064

Grant, William Nelson, III, M.D.  
USAMC/Dept. Infectious Disease  
428 CCCB  
Mobile, AL 36617

Smith, Kimberly Kay Edwards, M.D.  
UAB/Department Neurology  
UAB Station  
Birmingham, AL 35294

Goldman, Corey Keith, M.D.  
915 Stoneridge Road  
Birmingham, AL 35209

Hope, Terry Olivia, M.D.  
2764 Heritage Drive  
Pasadena, CA 91107

Pandya, Rajiv Dhruv, M.D.  
American Sports Medicine Institute  
P.O. Box 550039  
Birmingham, AL 35255

McGovern, Robert G., M.D.  
43 Bay Drive - Bay Point  
Department General Pediatrics  
Key West, FL 33040

Bhatt, Ashwin N., M.D.  
103 Popwell Street  
Department Internal Medicine  
Clanton, AL 35045

Blanchard, Susan Ann, M.D.  
821 South University Boulevard  
Department Family Practice  
Mobile, AL 36609

Brenner, Jeffrey Scott, M.D.  
1613 North McKenzie Avenue  
Department Radiology  
Foley, AL 36535

Buddendorff, Kenneth Augustus, III,  
M. D.  
Anesthesia Services, P.C.  
201 Cox Street

Mobile, AL 36604

Burke, David Fowler, M.D.  
Shoals Medical  
Billing/ Anesthesiology  
309 West State Street  
Muscle Shoals, AL 35661

Casey, David Thornhill, M.D.  
1717 North "E" Street, Suite 424  
Department Ophthalmology  
Pensacola, FL 32501

Castillo, Elquis Martin, M.D.  
418 Woodward Avenue, #11  
New Haven, CT 06512

Champion, William Jackson, M.D.  
880 Montclair Road  
Suite 375  
Birmingham, AL 35213

Chapman, Gregory Douglas, M.D.  
2412 Farthing Street  
Department Cardiology  
Durham, NC 27704

Chatterjee, Anjan Kumar, M.D.  
UAB/Department Neurology  
UAB Station  
Birmingham, AL 35294

Clarke, Ronald Wesley, M.D.  
Mostellar Medical Center/Ob-Gyn  
12701 Padgett Switch Road  
Irvington, AL 36544

Clemons, Linda Clemmons, M.D.  
201 Governors Drive  
Department Family Practice  
Huntsville, AL 35801

Cleveland, Robert Smith, M.D.  
3226 West Main Street, Suite 10  
Department Ob-Gyn  
Dothan, AL 36301

Collier, Brian Keith, M.D.  
701 University Boulevard, East  
Suite 808, Internal Medicine  
Tuscaloosa, AL 35401

Epremian, Barbara Ellen, M.D.

NW Alabama Cancer Center  
203 West Avalon Avenue, Suite 270  
Muscle Shoals, AL 35661

Eubanks, Kenneth Dewayne, M.D.  
9207 Kings Cross  
Department Neurosurgery  
San Antonio, TX 78250

Fernandez-Gatti, Emilio C., M.D.  
UAB/Department Neurology  
625 South 19th Street  
Birmingham, AL 35294

Genuardi, Frank Joseph, M.D.  
UAB/Dept. Pediatrics-Adolescent  
Medicine  
1600 7th Avenue South, 157 CHT  
Birmingham, AL 35233

Goodman, Laura J., M.D.  
800 Hillcrest Street  
Wintrop Square Building #5,  
Anesthesiology  
Mobile, AL 36691

Gottner, Michael John, M.D.  
416 North Seminary  
Department Ophthalmology  
Florence, AL 35630

Hendrix, Ernest Lee, M.D.  
201 Governors Drive  
Department Family Practice  
Huntsville, AL 35801

Herrick, David Phillip, M.D.  
1324 South Perry Street  
Department Anesthesiology  
Montgomery, AL 36104

Hockett, Richard Deane, Jr., M.D.  
UAB/Department Pathology  
618 South 18th Street, 220 W.  
Pavilion  
Birmingham, AL 35233

Janssen, Eric Wilfred, M.D.  
420 Lowell Drive, Suite 301  
Department Orthopaedic Surgery  
Huntsville, AL 35801

Keppler-Noreuil, Kim Michelle, M.D.

3621 Robin Circle-Pediatric Genetics  
Birmingham, AL 35242

Kirkpatrick, John Stewart, M.D.  
UAB / Division Orthopaedic Surgery  
1813 Sixth Avenue South, 601 MEB  
Birmingham, AL 35294

Kitchens, Jerry L., Jr., M.D.  
Surgical Associates, P.C.  
2018 Brookwood Medical Center  
Drive, Ste. G-2  
Birmingham, AL 35209

Kois, Jean Marie, M.D.  
3017 Asbury Park Place  
Department Dermatology  
Birmingham AL 35243

Lacey, Jane Eloise, M.D.  
Air University Regional Hospital  
Urology Clinic  
Maxwell AFB, AL 36112

Lanehart, William Henry, M.D.  
2121 Bee Ridge Road  
Department Pathology  
Columbia, SC 29223

Lockhart, Larry Randall, M.D.  
232 Walshwood  
Department Internal Medicine  
Mobile, AL 36604

Lopez, Pedro, M.D.  
DCH Medical Towers  
701 University Boulevard East,  
Suite 711  
Tuscaloosa, AL 35401

Lorance, Thomas Allen, M.D.  
1325 Military S.  
Department General Surgery  
Hamilton, AL 35570

McKenzie, William Stewart, Jr., M.D.  
Women's Medical Plaza-Ob-Gyn  
South  
2006 Brookwood Medical Center  
Dr., Ste. 40;  
Birmingham, AL 35209

Melvin, Al Leodus, M.D.  
5330 Walnut Grove Road  
Department Anesthesiology  
Memphis, TN 38120

Modling, Douglas Lucian, Jr., M.D.  
Urology Associates, P.C.  
1000 South 14th Street  
Birmingham AL 35205

Moore, John Reagan, M.D.  
UAB/Division Plastic Surgery  
619 19th Street South  
Birmingham, AL 35233

Moore, Joseph Clinton, M.D.  
116 Deerfield Drive  
Department Pathology  
Columbia, TN 38401

Moritz, Dennis Michael, M.D.  
UAB/Division Cardiothoracic  
Surgery  
1900 University Blvd., 760 THT  
Birmingham, AL 35294

Nakajo, Mona Marlene, M.D.  
114 Lincoln Street, Unit #F  
Pediatric Pulmonary  
Huntsville, AL 35801

Nielson, Eric Cline, M.D.  
UAB/Department  
Ob-Gyn, Resident's Office  
619 South 19th Street  
Birmingham, AL 35294

Noreuil, Todd O., M.D.  
3621 Robin Circle  
Internal Medicine  
Birmingham, AL 35242

Nunez, Juan E., M.D.  
2924 Ramada Drive, #104  
Tampa, FL 33613

Nunnally, Frederick Kent, M.D.  
Dothan ENT Center  
1602 East Main, Suite 402  
Dothan, AL 36301

Olash, Bart Martin, M.D.  
Rheumatology Associates of Mobile  
3658 College Lane South  
Mobile, AL 36608

Paulk, Wilson Guinn, M.D.  
4255 Carmichael Court North  
Department Ophthalmology  
Montgomery, AL 36106

Pena, Jose Raul, M.D.

1312 South 11 th Avenue  
Apartment #1  
Birmingham, AL 35205

Pervez, Aslam, M. D.  
Pickens County Medical Center P.O.  
Box 428 Carrollton, AL 35447

Phillips, Laura Grace, M.D.  
UAB/Pediatrics-Emergency Med.  
1600 Seventh Avenue South  
Birmingham, AL 35233

Reddy, Sadhana K., M.D.  
3014 South Cove Drive  
Pediatrics - General Medicine  
Birmingham, AL 35216

Robles, Harvey Bradford, M.D.  
UAB/Division Cardiology  
UAB Station - 521-E THT  
Birmingham, AL 35294

Rohrer, Heather Hall, M.D.  
Dothan Specialty Clinic  
3226 West Main Street, Suite 102  
Dothan, AL 36301

Roisum, Tony Craig, M.D.  
American Sports Medicine Institute  
P.O. Box 550039  
Birmingham, AL 35205

Sarasua, Martha Marion, M.D.  
3021 Cordyon Road  
Cleveland Heights, OH 44118  
After 8/01/92:  
Lakeview Center, Inc .  
1221 West Lakeview Avenue  
Pensacola, FL 32501

Schroeder, Ann Marie, M.D.  
4033 Countryside  
Dept. Internal Medicine  
Wichita, KS 67218

Thiene, Pamela Devon, M.D.  
1030 Fairfax Park  
Department Ophthalmology  
Tuscaloosa, AL 35406

Thomas, Paul Austin, M.D.  
Florence Clinic/Orthopaedics  
416 Seminary Street  
Florence, AL 35630

Veerula, Giridhar Rao, M.D.



2000 McMillan Avenue  
Department Pediatrics  
Bay Minette, AL 36507

Walker, Benjamin Harris, II, M.D.  
441 Alexander Street  
Department Anesthesiology  
Memphis, TN 38111

Walker, Thomas Atchley, M.D.  
Jefferson County Department Health  
1400 Sixth Avenue South/Pediatrics  
Birmingham, AL 35202

Warner, Jeffrey Calbeck, M.D.  
3821 Chace Lake Cove  
Department Pathology  
Hoover, AL 35244

Woods, Glenn Morgan, M.D.  
1705-B 14th Avenue South  
Anesthesiology  
Birmingham, AL 35205

Wyatt, Darrel Wayne, M.D.  
P. O. Box 7084  
Department Ob-Gyn  
Orange Park, FL 32073

Zimmerman, James Robert, M.D.  
South Baldwin Hospital/Emerg.  
Medicine  
1613 North McKenzie Street  
Foley, AL 36535

Landwehr, Craig Michael, M.D.  
2660 10th Avenue South, Suite 301  
Department Ob-Gyn  
Birmingham, AL 35205

Berry, Dirk Landon, M.D.  
Riverside Medical Center/Nephrology  
535 River Road East, Ste. 1-2  
Tuscaloosa, AL 35405

Levine, Ronald L., M. D.  
UAB / Division Cardiology  
UAB Station - 321 THT  
Birmingham, AL 35294

Eaton, Katulle Koli, M.D.  
American Sports Medicine Institute  
P. O. Box 550039  
Birmingham, AL 35255

Watts, Larry Thomas, M.D.  
UAB/Dept. Cardiothoracic Surgery

UAB Station  
Birmingham, AL 35294

Epps, Jesse Miller, M.D.  
3128 Harwick Drive  
Hoover, AL 35242

McCluskey, Leland Chester, M.D.  
Hughston Clinic-Orthopaedic Surgery  
328 Macon Street  
Eufaula, AL 36027

Margolies, Gary Richard, M.D.  
UAB/Div. Clinical Immunology-  
Rheumatology  
UAB Station - THT 413  
Birmingham, AL 35294

Pierson, Robert LeRoy, M.D.  
Hale County Hospital/Dept. Ob-Gyn  
508 Greene Street  
Greensboro, AL 36744

Straughn, Sherrie-Ann Veronica, M.D.  
6 Allen Parkway  
Department Clinical Dermatology  
Oxford, AL 36203

# Emergency Medicine Opportunity



## *Phenix City, Alabama*

Located in Southeast Alabama across the river  
from Columbus, Georgia. Annual ED volume of  
13,500 in this 300-bed hospital.

**SPECTRUM<sup>®</sup>**  
**EMERGENCY CARE**

A member of The ARA Group

P.O. Box 419052, St. Louis, MO 63141-8741

## *The Spectrum Advantages*

- Very competitive fees.
- High-limit occurrence-based malpractice insurance.
- Flexible schedules.

For details call  
Joyce Solomon or  
Carmine Iannotti at  
**1-800-325-3982**



# Soon, your practice could be run from here.

Most people agree that the U.S. health care system needs significant change. And if a single-payor, national system is adopted, it will change.

Some proposals under consideration would put the government in charge of America's health care. That kind of radical change could affect your freedom to make decisions in administering patient care. It could affect the way you're compensated. And how you use medical technology.

If you find these kinds of changes hard to swallow, maybe you should support a proposal that will build on what's good about America's health care system. And change what's not. A plan like Health Access America.

Developed by the American Medical Association, Health Access America was designed to preserve the integrity of the system while improving programs like Medicare and Medicaid, and requiring employer-sponsored health plans.

So while there's still time, speak for yourself. Join the AMA's call for reform. Call 1-800-AMA-3211 for more information on Health Access America.

## Health Access America

The AMA proposal to improve access to affordable, quality health care.

## American Medical Association

Physicians dedicated to the health of America





# The Alabama Physicians Recovery Network (PRN)

***(Formerly Impaired Physicians Program)***

Chemical dependency, alcoholism or other impairment can be a threat to your life, family and livelihood.

The Impaired Physician Program is managed by the Medical Association of the State of Alabama and provides:

- ◆ *Intervention*
- ◆ *Education*
- ◆ *Guidence to hospital, staff and employees*
- ◆ *Recovery monitoring*
- ◆ *Structured support groups*
- ◆ *Family assistance*
- ◆ *Advocacy*
- ◆ *Liason*
- ◆ *Quality Assurance*
- ◆ *Confidentiality*

***For information call: 1-800-239-MASA or 205-263-6441***  
***On weekends, after office hours and holidays call:***  
***1-205-271-5759***











